Section 12: Fast Cover Medical Authority Form

Complete this form if your claim is due to an accident, illness, disability or death.

The form must be completed by the patient (injured, ill or disabled person) whose illness or injury resulted in this claim or Executor of the Estate in the event of a death.

☐ I authorise Fast Cover or its representatives to obtain from any person or organisation any information regarding treatment for the condition(s) which resulted in this claim. I acknowledge that a photocopy of this authorisation shall be considered as valid as the original.

Claim Number:

Policy Number:

Patient's Full Name:

Patient's Date of Birth:

Patient's Signature:

Executor of the Estate's Full Name (if applicable):

Executor of the Estate's Signature (if applicable):

Name of Patient's usual GP/Dentist/Doctor/Medical Practitioner in Australia:

GP/Dentist/Doctor/Medical Practitioner Phone Number:

GP/Dentist/Doctor/Medical Practitioner Fax Number:

GP/Dentist/Doctor/Medical Practitioner Email Address:

GP /Dentist/Doctor/Medical Practitioner Practice Address:

Suburb: State: Postcode:

If your claim relates to a medical condition, you must have the Medical Certificate in Section 13 completed by the usual GP/Dentist/Doctor/Medical Practitioner in Australia of the patient (injured, ill or disabled person) **whose illness or injury resulted in this claim**. If we need further information from your GP/Dentist/Doctor/Medical Practitioner we will let you know.

Please return completed form to Fast Cover

Email Address	claims@fastcover.com.au (Please include claim number in email subject)
Phone Number	1300 409 322
Fax Number	02 8883 7002
Postal Address	Fast Cover Claims, PO box R1384 Royal Exchange NSW 1225

Section 13: Fast Cover Medical Certificate

This medical certificate is to be completed:

- at the claimant's expense
- by the patient's usual GP/Dentist/Doctor/Medical Practitioner
- for all claims related to medical, dental, or unexpected expense and cancellation claims resulting from an accident, illness, disability or death.

The medical practitioner is respectfully requested to give as much detail as possible in order for us to assist our client and avoid the necessity of additional enquiries.

Claim Number:

Claimant's Name:

1. Patient's Name: Patient's Date of Birth:

2. Are you the patient's usual GP? ☐ Yes ☐ No

2A. If yes, how many years/months?

2B. If no, please provide details regarding your involvement with the patient, and please provide details of the patient's usual GP:

3. What is the **precise diagnosis** of the injury or illness that resulted in the claim?

4. Date of onset of the injury or illness:

5. Date you were first consulted for this injury or illness:

5A. Date when symptom/s relating to the injury or illness first manifested?

5B. List the dates and description of the test(s), investigations, care, treatment, medical attention and medications you prescribed or performed.

5C. What was the outcome of the investigations, care, treatment, medical attention performed?

5D. Date when the results were advised to the patient:

6. Date of the most recent consultation for this injury or illness? What was the outcome?

7. Please outline any **other medical condition/s** of the patient which contributed directly or indirectly to the illness or injury leading to the claim, including the **dates of onset for each** medical condition/s (first commenced). Please also confirm if the medical condition/s are ongoing, or if the medical condition/s are resolved please provide the specific dates.

8. Was the patient under the care of any other Medical Practitioner or Specialist/s?

☐ Yes ☐ No

8A. If yes, please provide the details of the other Medical Practitioner or Specialist/s:

8B. Date first referred to a Medical Practitioner/Specialist:

8C. Name of Medical Practitioner/Specialist:

8D. Phone number of Medical Practitioner/Specialist:

8E. Email of Medical Practitioner/Specialist:

8F. Postal address of Medical Practitioner/Specialist:

8G. What was the outcome of this referral?

9. Have you previously treated or advised this patient for any same, similar or related symptom/illness/injury in respect to the diagnosis described in question 3? ☐ Yes ☐ No

9A. If yes, please provide details and rationale below:

9B. Please state when you last treated the patient, prior to the occurrence giving rise to this claim, and give details of the treatment and any medication prescribed:

9C. Was the patient advised to continue this treatment and/or medication:

Until departure on the Trip ☐ Yes ☐ No

Whilst on the Trip? ☐ Yes ☐ No

10. Did the Patient travel against your advice? ☐ Yes ☐ No

11. Are you prepared to certify that the Claimant(s) were required to cancel or reschedule their travel arrangements solely due to the condition described in question 3? ☐ Yes ☐ No

12. **Please attach copies of medical documentation within the last 3 years – including the Patient Health Summary, consultation notes, referral letters, hospital admission / discharge summaries relevant to the diagnosed condition described in question 3, and other medical condition/s of the patient which contributed directly or indirectly to the illness or injury leading to the claim.**

☐ I certify that the statements contained in this medical certificate are true and correct.

GP/Dentist/Doctor/Medical Practitioner Name:

GP/Dentist/Doctor/Medical Practitioner Signature:

Qualification:

Phone:

Fax:

Email:

Address:

Suburb: State: Postcode:

Please return completed form to Fast Cover

Email Address	claims@fastcover.com.au (Please include claim number in email subject)
Phone Number	1300 409 322
Fax Number	02 8883 7002
Postal Address	Fast Cover Claims PO box R1384 Royal Exchange NSW 1225

Privacy Statement

Your personal information is handled in accordance with our Privacy Policy, available at fastcover.com.au/privacy. The personal information requested on this form is collected for assessing claims and assisting us with administrative operations. Your information may also assist us in developing our products or services. Where required by law, your personal information may be disclosed to third parties, including related companies, advisers, people involved in claims, our agents and service providers. If you do not provide us with the information, we may not be able to process your claim