

# Pre-existing Ailment Certification

The Pre-existing Ailment Rule is applied in the first 12 months of membership of any cover where, in the opinion of a doctor, dentist or other practitioner appointed by Medibank Private, signs or symptoms of an ailment, illness or condition related to a claim were in existence at any time during the 6 months preceding the date of commencement of membership of that cover.

## 1. Authorisation by member (to be completed by member)

To Dr \_\_\_\_\_ or such other doctor as may have treated (member name)

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for the ailment, illness or condition of \_\_\_\_\_

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for which medical attention was given during the month(s) of \_\_\_\_\_

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I hereby authorise you to complete the following Certification of Medical Attendant in regard to the ailment, illness or condition indicated above. I also authorise you to give to Medibank Private or any health care organisation duly appointed by Medibank Private such further information in regard to such ailment, illness or condition as Medibank Private may require.

Member's name \_\_\_\_\_ Membership number \_\_\_\_\_

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Signature \_\_\_\_\_ Date / / \_\_\_\_\_ Contact phone number \_\_\_\_\_

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## 2. Certification of Medical Attendant (to be completed by doctor)

Our member has authorised Medibank Private to seek your cooperation in providing details concerning the above nominated ailment, illness or condition. Your assistance in this regard would be appreciated so that a claim submitted by the patient can be finalised.

With reference to the above, I hereby certify that your member,

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### 1. Was suffering from

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when they consulted me on / /

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### 2. According to the history given to me by the patient in relation to the above mentioned problems, the symptoms and/or signs had at that time been present for a period of (please specify)

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### 3. Patient was referred **to me by/by me to** (circle as relevant) Dr \_\_\_\_\_ on / /

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### 4. Brief history of present ailment, illness or condition

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### 5. Previous history of this or related ailments, illnesses or conditions, including previous operations

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(additional comments may be provided overleaf)

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Name of Doctor (print) \_\_\_\_\_ Signature \_\_\_\_\_ Date / / \_\_\_\_\_

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Address \_\_\_\_\_

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Telephone no. \_\_\_\_\_

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Once complete return the Certification to Medibank Private  
 GPO Box 9999 in your Capital City  
 or fax it to (03) 8456 6240  
 For all enquires please call 132 331

Information provided is correct at the date of issue and is based, in part, on information provided by you. Medibank Private membership, including entitlement to and payment of benefits, is subject to our Fund Rules. Premium rates, and the Fund Rules, change from time to time. Your personal information is handled in accordance with our Privacy Policy. You can view a copy of our Fund Rules and Privacy Policy at any of our Retail Centres, or online at medibank.com.au