Health Management **Program Form**

Benefits are only payable where:

- The services are required to enable the HIF member to undertake a health management program for the treatment of a health related condition;
- The health management program has been recommended to the member by an HIF recognised provider who has the member under their care for the treatment of the health related condition;
- All supporting documentation required by HIF in relation to the health management program has been completed in the manner required by HIF;
- The provider/facility is recognised by HIF; and
- The member holds the appropriate level of Extras cover.

Please note: This form will remain current for 2 years from the first date of service being claimed and then a new Health Management Program form will be required.

To be completed by the HIF member:

Member number: _____ Title: _____

First name: _____ Surname: _____

Date of birth: _____

To be completed by healthcare professional (GP, Specialist, Physio, etc):

- ☐ GP
- ☐ Specialist Medical Practitioner
- ☐ Physiotherapist
- ☐ Chiropractor
- ☐ Exercise Physiologist
- ☐ Occupational Therapist

Please note this form cannot be completed by the provider of the program (eg. a gym or a personal trainer).

Healthcare professional name: _____ Provider No.: _____

Address: _____

Phone Number: _____

Please indicate the diagnosed medical condition that this Health Management Program is intended to manage or improve:

- ☐ Diabetes
- ☐ Osteoporosis and Osteopenia
- ☐ Obesity (defined as BMI>30)
- ☐ Rehabilitation
- ☐ Orthopaedic Conditions
- ☐ Back Pain
- ☐ Musculoskeletal Conditions
- ☐ Cardiac Conditions
- ☐ Other

If other please list condition _____

Declaration - to be completed by your referring healthcare professional:

I declare that I have recommended the directive to undertake exercise is part of a health management program for the diagnosed medical condition listed overleaf and all the information on this form is true and correct.

Signature: Date:

Declaration - to be completed by the HIF member

I declare that I am undertaking a health management program for treatment of a health related condition. I acknowledge that I must notify HIF if I cease this program or enter into a new program. I consent to HIF collecting, using or disclosing my personal information for the purposes set out in the HIF Privacy Policy (which can be found at **hif.com.au**).

Signature: Date:

Once you have completed the form, please email it to us at **hello@hif.com.au** or mail to:

Claims Department, Health Insurance Fund of Australia
Whadjuk Country, GPO Box X2221, Perth WA 6847