AHSA INSULIN PUMP FUNDING APPLICATION FORM – REPLACEMENT / UPGRADE

This form provides confirmation of details relating to a Health Fund member applying for a replacement or upgrade of an Insulin Pump.

Patient Name:	Patient Date of Birth:
Health Fund:	Membership Number:

Confirmation of member eligibility for benefits to be payable

Hospital / Clinic Provider Number: _____

Hospital / Clinic Name: _____

Diabetes Educator's Name: _____

Contact Number: _____

Please tick the relevant box to indicate request for a pump replacement or upgrade

Replacement ☐ Upgrade ☐

Current Insulin Pump

Name: _____

Model number: _____ Date of purchase: _____

Details of new device

Model Number: _____ Prostheses List Benefit: _____

Prostheses List Rebate Code: _____

Reasons for upgrade or replacement

Treating Dr.letter attached ☐ Supplier Report attached ☐

General Conditions

Payment relating to this claim is not subject to the patient being formally admitted to hospital. However, the following conditions apply to payment of a benefit for insulin pumps:

- Benefits are only payable for insulin pumps included on the Department of Health and Ageing's Prostheses List as at the date of service;
- The insulin pump must be clinically necessary for the member;
- The member's cover must include benefits for the insulin pump; and
- The insulin pump must not be replacing a pump which is within the relevant warranty period (replacement eligibility/warranty is from date of fitting) except in the case of requests for an upgrade for a clinical reason.
- A clinical reason for the upgrade provided in the treating doctor's letter or evidence the insulin pump is no longer functioning or able to be supported must be provided.i.e. supplier report outlining fault with pump
- A request to upgrade to a more recent model is an insufficient reason to seek approval for funding

Application and Claims process

The application for a replacement / upgrade pump is to be submitted to the Health Fund and include this signed form and letter of clinical need from the treating doctor.

Following Health Fund confirmation of funding, the prosthesis invoice is to be sent directly to the insulin pump funding contact at the Health Fund for payment of benefits by direct EFT to the prostheses supplier.

Prostheses Supplier: Name:_____ Provider No. _____

Patient / Guardian Declaration

I declare that all the above information provided in connection with this application and claim is true and correct.

I authorise the prosthesis supplier to contact my Health Fund on my behalf in relation to the payment of the insulin pump invoice. I understand the treating doctor's letter and any other relevant documentation will be sent to my Health Fund on my behalf for the purpose of providing private health insurance in accordance with the Fund's privacy policy.

I authorise my Health Fund to contact the prosthesis supplier, diabetes educator, treating doctor or hospital in relation to these services and the payment of the insulin pump invoice if required.

I authorise the provider of the treatment or service to supply relevant information, if required, to my Health Fund for the purpose of providing private health insurance.

I authorise my Health Fund to pay benefits for the insulin pump directly to the prosthesis supplier.

Patient's / Guardian's Signature:_____ Date:_____

SECTION 2: TO BE COMPLETED BY THE HEALTH FUND

Health Fund:_____

Contact Name & Title:_____

Contact Phone number::_____

Contact Fax number:_____

Device Approved: Yes/No

Approved by (signature):_____

Date Approved:_____

If approved, Prostheses List benchmark benefit at date of service payable = $_____