Insulin pump funding application

This form is to request funding for an insulin pump. For an insulin pump replacement/upgrade, please use the Insulin pump replacement/upgrade application.
This form requests information from your endocrinologist, specialist clinician and the hospital relating to your funding request for an insulin pump.
This information will allow us to determine if a benefit is payable on the purchasing of an insulin pump.
Please write in capitals and ensure all fields are completed or HBF may not have sufficient information to review your request.
Please email completed form to providersubmissions@hbf.com.au and allow five working days for this request to be processed.

1 Member details To be completed by the member or policy owner.

Member number

Given names

Family name

Date of birth

Contact phone number

Email

2 Healthcare provider details To be completed by your treating endocrinologist or specialist clinician.

Given names

Family name

Medicare provider number

Contact phone number

Email

Is this the member's first insulin pump? ☐ Yes ☐ No

Has the member successfully trialled an insulin pump? ☐ Yes ☐ No

Is this funding request part of an in-hospital admission? ☐ Yes ☐ No

Name and model of pump

Prosthesis list billing code

Cost of insulin pump

Clinical requirements

The insulin pump is prescribed for the treatment of type one diabetes. ☐ Yes ☐ No

The insulin pump is to replace multiple daily injections. ☐ Yes ☐ No

Will the member have completed a comprehensive diabetes education scheme prior to receiving the insulin pump? ☐ Yes ☐ No

Does the member have a history of frequent hypoglycaemia? ☐ Yes ☐ No

Does the member have overnight fasting blood sugars frequently exceeding 9mmol/L? ☐ Yes ☐ No

Please advise the number of diabetes related hospital admissions the member had in the last 12 months.

Declaration to be completed by the healthcare provider

I declare that the information I have provided is true and accurate and the member has been made aware of the out-of-pocket expenses associated with insulin pump consumables and any outpatient consultation fees.

Signature

Continued over

3 Hospital provider details To be completed by the authorising hospital officer.

Name of hospital

Name of authorising hospital officer

Contact phone number

Email

Reason for admission (If inpatient, a Type C certificate must be provided)

Declaration to be completed by authorising hospital officer

I declare that the information I have provided is true and accurate and the member has been made aware of the out-of-pocket expenses associated with insulin pump consumables and any outpatient consultation fees as per declaration below.

Signature

4 Member signature and declaration

I declare and agree that:

- All the information provided above is true and accurate.
- The application for the pump is for the member named above or a dependant on the member's policy.
- I authorise the provider/s of that treatment or service to provide to HBF all information that is necessary for the funding request.
- I understand HBF does not pay a benefit towards the costs of consumables associated with the use of the insulin pump.

Name (please print)

Signature

General conditions

- All members must be a financial member of a complying hospital product.
- All relevant waiting periods must have been served.
- The benefit for an insulin pump is only payable once every four years provided all other conditions are met.

Your privacy

HBF Health Limited (**HBF**) complies with the *Privacy Act 1988 (Cth)* to ensure that your personal (including sensitive) information (**Information**) is protected. HBF will use the Information collected to assess and process your claim for an insulin pump. We may not be able to perform this function or only perform it to a limited extent if you do not provide us with your Information. HBF also engages third parties to carry out functions on behalf of HBF such as claims administration and they may collect the information you supply on this form and pass this information to HBF in order for HBF to assess and process your claim.

When you make the claim you consent to HBF collecting related sensitive information directly from the third parties described above or, if you are not the recipient of the treatment or service the subject of the claim, you give consent on behalf of that recipient.

HBF collects, uses and discloses your Information in accordance with our Privacy Policy, which is available at hbf.com.au or on request by calling an HBF member service advisor on 133 423. Our Privacy Policy contains further information about how HBF handles your Information. This includes information on how you can access and/or seek the correction of your Information that we hold about you as required by law, how to make a complaint about the way your Information is being handled by HBF and how HBF will deal with your complaint.

If you have any questions about how HBF handles your Information, please contact our privacy officer by writing to GPO Box C101, Perth, Western Australia, 6839.