



THE HOSPITALS CONTRIBUTION FUND OF AUSTRALIA LIMITED  
 ABN 68 000 026 746. A Registered Health Benefits Organisation.  
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## AUTHORITY

(to be completed by patient or patient's legal guardian)

### INSTRUCTIONS FOR COMPLETING FORMS

1. Please print your name and membership number and sign authority on side 1 of 2 prior to forwarding to your doctor.
2. The doctor you first consulted with this condition will need to complete this certificate. If this was not your regular general practitioner, please also complete the authority on side 2 of 2 and have your regular general practitioner complete page 2 of 2.
3. **\*DOCTOR/MEMBER: IF ALL SECTIONS OF THIS FORM ARE NOT COMPLETED, HCF WILL BE UNABLE TO REACH A DECISION AND IN TURN, BENEFITS MAY NOT BE PAYABLE**

To Dr. \_\_\_\_\_

I hereby authorise you to complete the Certificate of Attendant below and to provide any further information required by HCF in regard to the condition requiring hospitalisation.

Please return the Certificate to HCF in the enclosed prepaid envelope.

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

\*If the above Doctor is not your regular General Practitioner, please have your regular General Practitioner complete the Certificate on page 2 of 2.

### CERTIFICATE OF ATTENDANT

(To be completed by the doctor first consulted for the condition treated)

Are you the above member's regular General Practitioner?  YES  NO If so, for how long? \_\_\_\_\_

I hereby certify that \_\_\_\_\_ aged \_\_\_\_\_

was suffering from (Please print) \_\_\_\_\_

He/she first consulted me on the \_\_\_\_ / \_\_\_\_ / \_\_\_\_ for the above condition which has required/will require hospitalisation.

At that time, the signs/symptoms of this condition had been present for a period of \_\_\_\_\_ hours, \_\_\_\_\_ days, \_\_\_\_\_ months, \_\_\_\_\_ years prior to the first consultation.

Brief history of this condition including date/s of onset of signs/symptoms: \_\_\_\_\_

Prior to the initial consultation date above, my patient has previously consulted me on (date/s) in relation to other related condition/signs and/or symptoms. \_\_\_\_\_

If known, please advise nature or type of surgery required \_\_\_\_\_

Patient was referred by Myself/Dr \_\_\_\_\_ Title \_\_\_\_\_

Patient was referred to \_\_\_\_\_ Date referred \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I give my authority to HCF to supply a copy of this Certificate to the patient, if requested.  YES  NO Date completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature (of practitioner first consulted) \_\_\_\_\_

Name \_\_\_\_\_ Provider number \_\_\_\_\_

Address \_\_\_\_\_

Post code \_\_\_\_\_ Business number \_\_\_\_\_

### IN OBSTETRIC AND BIRTH RELATED CASES, PLEASE STATE:

1. Date of last menstrual period \_\_\_\_\_ 2. Expected date of confinement \_\_\_\_\_

3. The baby's birth weight\* \_\_\_\_\_ 4. The estimated gestation\* \_\_\_\_\_

\*if post natal

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Member's signature \_\_\_\_\_

### CERTIFICATE OF ATTENDANT

(To be completed by the patient's General Practitioner)

How long have you been the above member's regular General Practitioner? \_\_\_\_\_

I hereby certify that \_\_\_\_\_ aged \_\_\_\_\_

was suffering from (Please print) \_\_\_\_\_

He/she first consulted me on the \_\_\_\_ / \_\_\_\_ / \_\_\_\_ for the condition noted overleaf which has required/will require hospitalisation.

At the time of the initial consultation on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ the signs/symptoms of this condition had been present for a period of  
\_\_\_\_ hours, \_\_\_\_ days, \_\_\_\_ months, \_\_\_\_ years prior to that consultation.

Brief history of this condition including date/s of onset of signs/symptoms: \_\_\_\_\_

Prior to that initial consultation date above, my patient has/has not previously consulted me on (date/s) in relation to other related condition/signs and/or symptoms. (Please provide details) \_\_\_\_\_

If known, please advise nature or type of surgery required \_\_\_\_\_

Patient was referred to \_\_\_\_\_ Date referred \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I give my authority to HCF to supply a copy of this Certificate to the patient, if requested.  YES  NO Date completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature \_\_\_\_\_

Name \_\_\_\_\_ Provider number \_\_\_\_\_

Address \_\_\_\_\_  
Post code \_\_\_\_\_ Business number \_\_\_\_\_

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