



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

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.

ORDER FORM FOR MINIMED[®] 640G System (INSULIN PUMP & PERSONAL CGM)

How to complete Medtronic Order Form

A. Healthcare Professional to complete: Section 1-4.

a. If using a Hospital Purchase Order

- Complete all Sections except Delivery Address in Section 1.
- Clinician to Sign and Date at Section 7 OR patient to sign and date at Section 6.
- Email Medtronic Order Form and Written Hospital Purchase Order to australia.diabetes@medtronic.com (preferred communication method) or fax 02 9857 9237.
- **Note:** Goods will be delivered to Hospital Store as per details on the Hospital Purchase Order.

b. If not using a Hospital Purchase Order

- Complete all Sections.
- Email the following documents australia.diabetes@medtronic.com (preferred communication method) or fax them to 02 9857 9237.
 - Medtronic Order Form (clinician to Sign and Date at Section 7 OR patient to sign and date at Section 6)
 - Health Fund Confirmation (if the Health Fund have already approved the product and you are not intending to use the MDT Health Fund Approval Process); **OR** provide the relevant Health fund Form as below to enable the MDT Health Fund Approval Process:
 - AHSa Funding Application Form (initial or upgrade); **or**
 - Medibank Funding Application Form (completed with patient's signature and approval reference number); **or**
 - AHM/HCF/Teachers Health/health.co.au/HBF Insulin Pump Funding Application Form.
 - Letter of Clinical Need (this is now a requirement for all Health Funds)
 - If this is an upgrade of a pump and the health fund is an AHSa fund, we will require the Letter of Clinical Need to detail the defects with the pump and the clinical need for a new pump.
- **Note:** Goods will be delivered to Hospital / Clinic address as per details provided on Medtronic Order Form.

B. Patient to complete: Section 5 and 6.

- Please complete Section 6 in full with reference to the entirety of this document.
- Complete Section 5 (only if purchasing Medtronic CGM).
- Email or Fax Form to Medtronic, or return to your healthcare professional.

If you have any questions about this form, please contact Medtronic Diabetes on 1800 777 808 (Option 3).

FOR MEDTRONIC INTERNAL USE ONLY – INSIDE SALES CHECKLIST				
PHI Order	HCP Signature OR Patient signature	<input type="checkbox"/>	Health Fund Form/Confirmation of funding letter	<input type="checkbox"/>
			Letter of Clinical Need	<input type="checkbox"/>
PURCHASE ORDER	HCP Signature OR Patient signature:	<input type="checkbox"/>	PO Document	<input type="checkbox"/>

ORDER FORM FOR MINIMED® 640G System (INSULIN PUMP & PERSONAL CGM)

Section 1: Hospital Information and Delivery Address					
Using Hospital Purchase Order (excludes CGM)		<input type="checkbox"/> YES <input type="checkbox"/> NO			
Name of Hospital					
Unit / Clinic					
Delivery Address (If not using Hospital Purchase Order)					
Date Required (at Hospital Stores / Clinic)		Admission Date			
Name of Diabetes Educator		Contact Phone No			
Name of Prescribing Clinician					
Name of Referring Clinician					
Section 2: Patient's Information					OFFICE ONLY
Name of Patient		Date of Birth		FOC-L <input type="checkbox"/>	
If minor, Parent's Name		Diagnosis: Type 1 or Type 2 Diabetes			
Patient Address		Suburb			
		State		Postcode	
Patient Contact Phone No		Mobile No			
Email address					
Email address & email opt in for free silicone case		<input type="checkbox"/> I would like to receive a free silicone case by opting in to receive important product information and other marketing information from Medtronic via email: Generic design: Blue <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Purple <input type="checkbox"/> Pink <input type="checkbox"/> Lenny the Lion design: Blue <input type="checkbox"/> Orange <input type="checkbox"/> Purple <input type="checkbox"/>			
Health Fund		Membership No			
Section 3: Pump Ordering Information					
<input type="checkbox"/> New pump purchase		<input type="checkbox"/> Upgrade from Medtronic pump		<input type="checkbox"/> Existing Bridging the Gap patient	
<input type="checkbox"/> Upgrade from other brand (please specify existing brand and model)					
Product Description (please tick the model you would like to order)		Price AUD\$ (GST exempt)	Rebate Code (Prostheses List Sep 2014)		
MiniMed® 640G Insulin Pump (MMT-1751)		\$9,500.00	MI150		
Please select the Colour Required:		Blue (B) <input type="checkbox"/>	Black (K) <input type="checkbox"/>	White (W) <input type="checkbox"/>	Purple (P) <input type="checkbox"/>
				Pink (H) <input type="checkbox"/>	
Section 4: CGM Order Details					
Please tick ONE option below to indicate if you wish to order CGM technology and to utilise the following offer – your payment details will then be taken overleaf (page 3), processed and then page 3 will be destroyed					
CGM Protector Kit - Product: BN1AUCGMSTRKIT & MMT-7008A - Includes a Guardian 2 Link™ transmitter kit and 10 Enlite™ sensors Special offer valid within 3 months of pump start – \$1,449 each \$750 each (48% off RRP)					
Option 1 Ship Guardian 2 Link™ + 5 sensors now, and ship remaining order in 6 weeks (pay \$375 now, and \$375 in 6 weeks) OR -		<input type="checkbox"/>	Option 2: OR Ship all at once (pay \$750 upfront)		<input type="checkbox"/>

ORDER FORM FOR MINIMED[®] 640G System (INSULIN PUMP & PERSONAL CGM)

Section 5: CGM Ordering & Payment Information (optional; only if purchasing CGM with a Medtronic insulin pump)

DATE CGM REQUIRED:		CGM TRAINING DATE:		
Qty	Product Number	Product Description	Price AUD\$ (GST exempt)	Total Price AUD\$ (GST exempt)
1	BN1AUCGMSTRKIT & MMT-7008A	<p>CGM Protector Kit</p> <p>Includes a Guardian 2 Link™ transmitter kit and 10 Enlite™ sensors</p> <p>- Special offer valid within 3 months of pump start -</p> <p>Select one:</p> <p><input type="checkbox"/> Ship Guardian 2 Link™ + 5 sensors now, and ship remaining order in 6 weeks (pay \$375 now, and \$375 in 6 weeks)</p> <p><input type="checkbox"/> Ship all at once (pay \$750 upfront)</p>	<p>\$1,449 each</p> <p>\$750 each (48% off RRP)</p>	

Check this box if you wish to contact Medtronic directly on **1800 777 808** to make your purchase.

OR complete your details below;

Money Order Cheque (payable to: Medtronic Australasia and post to PO Box 945, North Ryde NSW 1670)

Credit Card Card type _____ Card number _____

Expiry Date _____ Security Code _____

Amount to charge now \$ _____

Amount to charge in 6 weeks \$ _____

Cardholder's name _____

Signature _____ Date _____

Terms & Conditions of CGM Purchase:

- If payment is made by money order or cheque, please send the order form with your payment. The order will not be shipped until the money order or cheque is cleared. Please allow maximum 3 weeks for bank clearance and delivery.
- Delivery is ex stock (Sydney) via courier.
- Special CGM offers are available only to users of Medtronic personal CGM-ready devices.
- The glucose sensor storage temperature is between 2°C and 30°C at all times. Shelf life of the sensors is 6 months from date of manufacture. We ensure that sensors have a minimum of 60 days' shelf life remaining when they are shipped out to customers from Medtronic Australasia. Always check the expiry date of your glucose sensors before storing. No returns will be accepted for expired glucose sensors.

This page of the form contains personal information and is only to be used by authorised Medtronic staff. This document will be destroyed as soon as it is no longer required

ORDER FORM FOR MINIMED[®] 640G System (INSULIN PUMP & PERSONAL CGM)

ATTESTATION AND PRIVACY INFORMATION

Privacy: Medtronic is committed to protecting our pump user's privacy and personal information and will only use personal information for the purposes for which it was collected, in accordance with the privacy policy located at www.medtronic.com.au.

Your personal and health information including details of your diabetes and private health insurance (Protected Information) is collected and used by Medtronic Australasia Pty Ltd and its affiliates to assist you concerning your purchase and use of Medtronic diabetes products and services, for product-tracking purposes (as required by regulation) and to inform you about special offers and other information relating to our products, services and technological developments. In some cases (for example, where a product order is placed) we collect your Protected Information from your treating healthcare professional rather than directly from you, but will only do so if necessary for the purpose of administering a product or service to you. Your Protected Information may be held in our secure international databases, which are maintained by Medtronic affiliates and/or third party providers. However, we will not disclose your Protected Information to these parties unless their privacy practices comply with our Privacy Policy (see www.medtronic.com.au) and the data protection laws of Australia and New Zealand. For privacy queries, to opt out of receiving information about offers, products, services and/or technological developments; or to access/update your Protected Information, please phone toll free (AUS 1800 668 670) or write to PO Box 945, North Ryde, NSW 1670, Australia

Medtronic does not generally collect information that is sensitive personal information like financial information. However we may on occasion collect information in order to facilitate the purchase of Medtronic products and subscriptions. Such information will only be collected from you and will only be used for the purpose for which it was collected. We do not disclose sensitive personal information to third parties without your permission or instruction.

Disclaimer: Medtronic has put in place safeguards to protect the sensitive information we hold from misuse, loss and unauthorized access, modification or disclosure once your information is in Medtronic's possession. Medtronic stores the sensitive information you provide to us on computer servers, which are password protected for limited access and are located in controlled facilities. While Medtronic cannot guarantee against any loss, misuse or alteration to data, we take reasonable steps to prevent such occurrences.

-END-

Section 6: Patient Attestation and Signature/Date *(Stamps are not acceptable. Signature and date must be handwritten.)*

Please tick **all that apply**:

I give consent for Medtronic to liaise with my health fund on my behalf in order to attempt to secure funding in respect of the Medtronic 640G Insulin Pump. (Please note that if you do not wish for us to do so, we will take this to mean that you/your healthcare team are to liaise with your health fund independently to secure funding in respect of this order.)

I give consent for my healthcare professional to submit my sensitive personal information on my behalf to Medtronic to enable them to process this order (please note that if this is not signed, we understand that you will submit this information directly to us to enable us to process your order).

I confirm that I have read and understood the privacy statement above. I consent for Medtronic to collect and store my sensitive personal details contained in this form in accordance with the Medtronic Privacy Policy. I also give permission for my HCP to share any other data on my behalf as required for the facilitation on purchasing this medical device.

Patient Signature: _____ Date: _____

Section 7: Health Care Professional Attestation and Signature/Date *(Stamps are not acceptable. Signature and date must be handwritten.)*

I certify that I am a registered medical practitioner and that the named patient is indicated for treatment using the Medtronic therapies ordered on this form. A copy of this order will be retained as part of the patient's medical record.

I give my consent to Medtronic to liaise with the patient's health fund on my behalf and that I confirm that I have communicated the privacy statement above to my patient and obtained their permission to share their personal and sensitive data with Medtronic.

I understand that Medtronic disclaims all liability with respect to the falsification or modification of this attestation of clinical need and my confirmation that my patient consents to my sharing of their data with Medtronic.

Prescribing Clinician's Signature: _____ Date: _____