HCF Insulin pump funding application

HCF Membership No.

Complete and fax to:
02 9248 9423

or email to:
clinicalreviewemail@hcf.com.au

1 Your personal details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title | First name | Middle initial

Surname | Sex (Please mark 'X') M ☐ F ☐ | Date of birth (DD MM YYYY)

2 To be completed by your treating Endocrinologist/Diabetes Educator (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Health care provider's name

Medicare provider number | Phone | Postcode

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

Date last insulin pump was received (DD MM YYYY)

Is member currently using a temporary pump? Yes ☐ No ☐

Reason for insulin pump

Member's HbA1c %

Date of HbA1c measurement (DD MM YYYY)

Please provide details of any hospital admissions in the last year related to diabetes

Manufacturer/model: MEDTRONIC

Prosthesis list billing code: MI150

Price: $9,500.00

Declaration
To be completed by the Medical Practitioner

I declare that the information I have provided is true and complete.

Medical Practitioner signature and practice stamp or details X

Date (DD MM YYYY)

3 Declaration
To be completed by the Policyholder or Partner listed on policy

I declare all information provided in support of this application is true and complete and that all persons covered by this application whose personal (including sensitive) information is being disclosed to HCF have been made aware of the HCF Privacy Policy.

I acknowledge that HCF deals with personal information of all members in accordance with its privacy policy. I authorise, and have the consent of the patient, where necessary, to authorise HCF to contact the provider(s) and to access any information including health information needed to verify this application.

How HCF collects, uses, discloses (which may include obligations to overseas recipients in compliance with its privacy obligations) and keeps and secures personal information including how to opt out from direct marketing, how to request access to and correction of your personal information or how to complain about a privacy breach and how this is handled by HCF is explained in the HCF Privacy Policy. For a copy of this policy, call our member services team on 13 13 34 or go to hcf.com.au

Signature must be of the policyholder or partner listed on policy X

Date (DD MM YYYY)

For more information on insulin pumps please refer over page.

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- All members must be a financial member of a complying hospital product
- All relevant waiting periods must have been served
- HCF does not offer a benefit for lost, stolen or damaged insulin pumps
- Consumables for insulin pumps are available through the National Diabetes Services Scheme
- Please allow one week for processing of this request.

Commencement of insulin pump therapy

Outpatient care

HCF will offer 100% of the benefit listed on the Department of Health Prosthesis List for an insulin pump as an outpatient procedure upon the receipt of this form.

In hospital admission

HCF will provide a benefit for an insulin pump listed on the Prosthesis List for an inpatient admission provided the Type C certification is completed in accordance with the legislation. **Please note** that education is not a valid reason for hospitalisation. At times HCF may require additional information to verify the reasons for hospitalisation.

Continuation of insulin pump therapy

Outpatient care

HCF offers a benefit towards the replacement of insulin pumps once every five years. HCF may offer members a pro-rata benefit if they wish to replace their insulin pump sooner, but not while it is under warranty.

Benefits depend upon the member's level of continuous cover with an HCF hospital product since the previous pump was funded. Note: insulin pumps are excluded on some products. Please refer to your individual product information or phone 13 13 34.

Hospitalisation of members already on insulin pump therapy and with stable diabetes should not be necessary. If members are hospitalised, in addition to Type C certification, HCF may require additional clinical information to verify the reasons for hospitalisation.

Important information for members

Please note, any admission to hospital for insulin pump treatment must be accompanied by valid Type C certification. This needs to be filled out by your treating medical practitioner and received by HCF as part of your hospital claim.

HCF is not required to provide benefits for a hospital admission for insulin pump initiation or replacement where no valid Type C certification is received.

The Hospitals Contribution Fund of Australia Limited. ABN 68 000 026 746
AFSL 241 414. HCF Life Insurance Company Pty Limited. ABN 37 001 831 250
AFSL 236 806

HCF House, 403 George Street, Sydney, NSW 2000
Postal Address, GPO Box 4242, Sydney NSW 2001
hcf.com.au 13 13 34

Email this form and Hospital Purchase Order to: australia.diabetes@medtronic.com
Or Fax 02 9857 9237
All sections must be completed for order to be processed (please print clearly)
Allow 7 working days for delivery to hospital stores once order is processed

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.
  a. Medtronic Order Form (clinician to Sign and Date at Section 7 OR patient to sign and date at Section 6)
  b. 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.
  c. Letter of Clinical Need (this is now a requirement for all Health Funds)
  d. 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**	☐	**Health Fund Form/Confirmation of funding letter**	☐
			Letter of Clinical Need	☐
PURCHASE ORDER	**HCP Signature OR Patient signature:**	☐	**PO Document**	☐

Medtronic
Further, Together

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Section 1: Hospital Information and Delivery Address			
Using Hospital Purchase Order (excludes CGM)	☐ YES ☐ 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** ☐
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	☐ 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 ☐ Black ☐ White ☐ Purple ☐ Pink ☐ **Lenny the Lion design:** Blue ☐ Orange ☐ Purple ☐			
Health Fund		**Membership No**		

Section 3: Pump Ordering Information		
☐ **New pump purchase**	☐ **Upgrade from Medtronic pump**	☐ **Existing Bridging the Gap patient**
☐ **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) ☐	Black (K) ☐	White (W) ☐	Purple (P) ☐	Pink (H) ☐

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 -***	☐	***Option 2:*** *OR Ship all at once (pay $750 upfront)*	☐

Medtronic
Further, Together

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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	**CGM Protector Kit** Includes a Guardian 2 Link™ transmitter kit and 10 Enlite™ sensors **- Special offer valid within 3 months of pump start –** **Select one:** ☐ Ship Guardian 2 Link™ + 5 sensors now, and ship remaining order in 6 weeks *(pay $375 now, and $375 in 6 weeks)* ☐ Ship all at once *(pay $750 upfront)*	~~$1,449 each~~ **$750 each (48% off RRP)**	

☐ 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 2^0C and 30^0C 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

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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:** _____