Initial Insulin Pump Funding Application

This form should be used to request funding for an initial insulin pump only.

This form can be completed on-line by typing in the fields below. Once completed please return by email to providersubmissions@hbf.com.au. **Please allow 5 business days for a response.**

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

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 pump **(excl. GST)**

Intended fitting date

/ /

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.

Other clinical information relevant to the application

Letter from endocrinologist providing clinical reasoning for insulin pump attached. ☐ Yes ☐ No

Declaration to be completed by the Endocrinologist or specialist clinician

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 the insulin pump and related procedure, insulin pump consumables and any outpatient consultation fees.

Signature

Continued over

3 Hospital or clinic details To be completed by Credentialed Diabetes Educator or Hospital Administration Officer

Name of hospital or clinic

Name of Credentialed Diabetes Educator or Hospital Administration Officer

Contact phone number

Is this funding part of an in-hospital admission? ☐ No ☐ Yes - If yes, a valid type C certificate must be supplied with the claim

Declaration to be completed by Credentialed Diabetes Educator or Hospital Administration 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 the insulin pump and related procedure, insulin pump consumables and any outpatient consultation fees.

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 conditions must be met for any approval to remain valid)

- **Member must hold a financial hospital product that includes cover for insulin pumps on the date of fitting.**
- All waiting periods must have been served.
- Benefits towards an insulin pump are only payable after the warranty period has expired providing all other criteria is met.
- No benefit is payable for replacement of an insulin pump that has been lost, stolen or damaged.

Privacy statement

If you are a provider HBF will use your personal information collected on this form to administer and audit private health insurance claims and to prevent, detect and follow up fraudulent or invalid claims or misrepresentations. HBF may not be able to perform these functions if you do not provide HBF with your personal information. HBF may disclose your personal information to government or industry bodies, including my relevant professional association, and to external consultants to analyse your billing practices and review the claims history and claiming patterns of HBF members.

HBF will otherwise collect, hold, use and disclose your personal information in accordance with HBF's Collection Statement: Providers / Health Practitioners and Privacy Policy which is available at hbf.com.au/about-hbf/legal/privacy-policy or on request by calling a HBF Member Service Advisor on 133 423. These documents contain further information about how HBF handles your personal information.

If you are a member, by submitting this form, you consent to, and if you are a guardian, you consent on behalf of your dependent named on this form to, HBF:

- collecting personal (including sensitive) information relating to you and your dependant (if any) from the third parties mentioned in this form; and
- handling personal (including sensitive) information relating to you and your dependant (if any) in accordance with **HBF's Private Health Insurance Collection Statement** and **Privacy Policy** which are available at www.hbf.com.au.

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 or by telephoning 1300 883 530.