St.LukesHealth
Insulin Pump Funding Application Form

This form is to request funding for an insulin pump replacement or upgrade. Before completing this form, please check your eligibility for this benefit by calling us on **1300 651 988**. Please ensure that all details are correct prior to submitting this form.

Member Details			
Membership Number:			
Name of Member:		Birthdate:	

Healthcare Provider Details - To be completed by your treating Endocrinologist and Diabetes Educator			
Hospital/Clinic Provider Number:			
Hospital/Clinic Name:			
Diabetes Educator's Name:		Contact Number:	
Email Address:			
Signature:		Date:	
Treating Endocrinologist Name:			
Signature:		Date:	

Is the request for a pump replacement or pump upgrade? ☐ Replacement ☐ Upgrade

Reasons for upgrade or replacement:

Current Insulin Pump Details:			
Name:			
Model Number:		Date Of Purchase:	

New Insulin Pump Details:			
Model Number:		Prostheses List Benefit:	
Prostheses List Rebate Code:			

Please ensure the following supporting documents are attached:

☐ **Letter From Treating Doctor.**
(Must include evidence such as clinical history and blood sugar level results)

☐ **Supplier Report**
(Must include evidence such as work report, need for upgrade, pump is no longer functioning etc.)

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General Conditions

Please note that payment of this claim is not subject to the member being formally admitted to hospital.
The following conditions apply to the benefit payment for replacement or upgraded insulin pumps.

1. The benefit is only payable for eligible insulin pumps that are included on the Department of Health's Prostheses List as at the date of service;
2. It must be clinically necessary for the member to need an insulin pump;
3. The member must be covered by a St.LukesHealth policy that includes benefits for insulin pumps and have served any relevant waiting period(s);
4. The replacement of the insulin pump is not permitted when within the relevant warranty period (from date of fitting) unless the request for an upgrade is clinacally required.
5. If included in cover, an excess will apply towards the cost of a prothesis.

Application and Claims Process

Please submit the following documents to St.LukesHealth:

1. **Insulin Pump Funding Application Form**
2. **Letter from Treating Doctor.**
3. **Supplier Report**
4. **Prostheses Invoice**

Payment of benefit will be made via direct EFT to:

Prostheses Supplier Name:		Provider Number:	

Declaration

☐ I declare that the information I have provided is complete and correct.

Member's Signature:		Date:	

CLEAR FORM PRINT FORM EMAIL FORM