Medical Certification Form

goinsurance travel

TERMS AND CONDITIONS

- This form must be completed by the usual doctor of the person whose state of health, injury or death has given rise to a Cancellation or Curtailment claim.
- **This form does not need to be completed for Medical Expenses claims, or if the trip was curtailed due to your state of health (unless specifically requested).**
- Any charges or fees incurred for the completion of this form must be paid for by the claimant and are not recoverable under the claim.
- **The original form must be posted to our office at PO Box 5964, Brendale, Qld, 4500.**
- **Faxed or scanned copies will not be accepted.**

IMPORTANT NOTICE TO DOCTORS: We respectfully request you answer the following questions with as much details as possible in order to assist with the assessment of the claim and to avoid the necessity of further queries.

POLICY INFORMATION

Certificate number:

Name of claimant:

PATIENT DETAILS

Patient's full name:

Patient's address:

Suburb:

State:

Postcode:

Patient's date of birth: ☐☐/☐☐/☐☐

Patient's date of death (if applicable): ☐☐/☐☐/☐☐

Are you the patient's regular doctor? Y N

If yes, for how long? ☐☐ years ☐☐ months

PARTICULARS OF ILLNESS OR INJURY

Please provide a precise description of the illness or injury which has given rise to this claim:

When did the patient first become ill or sustain this injury? Date: ☐☐/☐☐/☐☐☐☐ Time: AM / PM

When were you first consulted for this illness or injury? Date: ☐☐/☐☐/☐☐☐☐ Time: AM / PM

Is the illness or injury caused by or traceable to a recurring or chronic illness or condition? Y N

If yes, please provide details below :

Has the patient suffered from the same or similar condition previously? Y N

If yes, please provide full history below :

Has the patient been awaiting / receiving tests, investigations or treatment for this or a related condition/s? Y N

If yes, please provide full details below, including relevant dates:

Please provide full details of any medication the patient has been prescribed, including dosage:

In the event of pregnancy please provide: The EDD ☐☐/☐☐/☐☐☐☐ The LMP ☐☐/☐☐/☐☐☐☐

Please describe any complications experienced in this or any prior pregnancy:

Do you consider the patient (if claimant) would have been fit to travel as planned? Y N

Did you advise the patient (if claimant) to cancel or curtail their scheduled trip? Y N

Your name:

Your signature:

Date signed: ☐☐/☐☐/☐☐

Your contact number:

ATTENTION DOCTORS: By completing and signing this form you declare that you have examined this patient and/or have referred to their medical records and confirm the information you have provided is true and correct.

If the patient is the claimant, please also provide a copy of their medical history and clinic notes (if applicable).