GUHealth

Health Management Services authorisation

Please print in black ink, using capital letters and mark check boxes with an X.

GU Health Membership No.

Under GU Health's Health Management Services benefits, you can claim towards the cost of an accredited or recognised program designed to address or improve a specific health or medical condition.

Ask your GP, medical specialist or recognised health provider e.g. physiotherapist, chiropractor or osteopath to complete and sign this form before you start your treatment.

***This form is valid for a maximum of 12 months from the effective date stated in Section 2.**

Please complete the information requested below and send your completed form by:

• Scan and email to corporate@guhealth.com.au; **or** • FreePost to GU Health, Reply Paid 2988, Melbourne Vic 8060 (no stamp required

For assistance or more information call your GU Health Member Relations Team on **1800 249 966** between 8.30am and 5pm (AEST) Monday to Friday **or** email **corporate@guhealth.com.au**

Section 1: Membership holder's details (the person in whose name membership is held)

Title

Surname

Gender M F

Given name

Date of birth D D M M Y Y Y Y

Home address

State

Postcode

Work telephone number

Home telephone number

Mobile number

Email address

Section 2: To be completed by your general practitioner, specialist or recognised health provider

Patient's name

Practitioner's name

Provider number

Telephone number including area code

Postcode

Please indicate the medical condition that this program is addressing

Please indicate the program you're recommending to improve or address the patient's medical condition

Start date of program/treatment D D M M Y Y Y Y

Please indicate the length of time (months) recommended for this course of treatment

Declaration (must be signed)

I declare and acknowledge that all the information I have provided in this form is correct. I understand that there are penalties for giving false or misleading information. Should any of the above details change, I'll notify GU Health immediately.

Practitioner's signature and practice stamp or Provider number

Date signed D D M M Y Y Y Y