NATIONAL PRIVATE PATIENT HOSPITAL CLAIM FORM

Private Health Fund | Hospital

Hospital Provider Number | Hospital Record Number

1. PATIENT / FUND MEMBERSHIP DETAILS (Please print and insert ticks (✓) in boxes)

Family Name of Patient | Mr/Mrs/Miss/Ms

Given Names of Patient

Membership Number | Level of Cover

Relationship of Patient to Member | Patient's Date of Birth / / | Age

Family Name of Member | Mr/Mrs/Miss/Ms

Given Names of Member

Residential Address of Member

Postcode

Is this a permanent address? Yes ☐ No ☐ Email

Telephone: Home ( ) Work ( ) Mobile

Adding a newborn child to your family membership: Sex | Date of Birth / /

Family Name | Given Names

Full name of Admitting Medical Practitioner:

2. DECLARATION CONCERNING CLAIM (The accurate answers to these questions are an essential part of this claim)

Patient/Guardian to complete (please tick (✓) below)	**Yes**	**No**
Do you have entitlement to claim compensation or damages (including previous settlements)?	☐	☐
Have you lodged a claim for compensation or damages?	☐	☐
Did the injury or condition occur at work, going to or from work or as a result of being at work?	☐	☐
Did the hospitalisation result from a motor vehicle accident?	☐	☐
Did the hospitalisation result from any other type of accident?	☐	☐
Does the patient have an entitlement to free treatment under Australian Veterans' legislation?	☐	☐
Is the patient a full-time student dependant over 17 years and under 25 years?	☐	☐

If yes, name of educational institution:

Date patient was first aware of symptoms: / / Date patient first consulted a doctor for symptoms: / /

Were the financial implications of your hospital charges explained prior to admission? ☐ ☐

Have you signed an Election Form to elect to be treated as a private patient? (PUBLIC HOSPITAL PATIENTS ONLY) ☐ ☐

☐ **I hereby declare and warrant that all the above information provided in connection with this claim is true and correct.**

☐ **I authorise the hospital, or any other authorities concerned with this hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all information, including Hospital Casemix Protocol information as required by the Federal Government, to the private health fund for the purpose of providing private health insurance in accordance with the fund's privacy policy.**

☐ **I authorise my health fund to pay benefits directly to the hospital.**

Patient's/ Guardian's Signature: **Date:** / /

3. HOSPITAL ACCOMMODATION DETAILS (To be completed by Hospital: please see overleaf for codes.)

Admission Date: / / Separation Date: / /

Admission Code	Accomm. Code	Date From	Date To	Discharge Code	Days Claimed	Payment Type Code	Amount Charged
						☐ Other:	
						☐ Other:	
						☐ Other:	
						☐ Other:	

Same Day Patients Only (Please tick (✓) boxes below)

Admission Time (24hr) : | Separation Time (24hr) : | Same Day Band (1-4)

Anaesthetic: None ☐ Local ☐ Intravenous ☐ Regional ☐ General ☐

Time in Theatre (ALL EPISODES – 24 hr)

From : To :

From : To :

From : To :

Theatre/MBS (*Principal MBS first)

MBS Item	Date of Service	Amount Charged
*		

Other Services

Code	Date of Service	Number	Amount Charged

Certificates Attached:

Please tick (✓): Acute ☐ Psych. ☐ Rehab. ☐ ICU ☐ NICU ☐ Pt. Election ☐

Same Day Certification

☐ (See Section 4 overleaf)

Diagnoses / Procedures / Other Details

DRG | DRG VERSION | PRINCIPAL DIAGNOSIS ICD-10-AM

Additional Diagnoses ICD-10-AM					
Procedure Codes ICD-10-AM (*Principal Procedure first)	*				
Infant/Neonate Weight	Age in Days	Urgency of Admission	Mode of Separation	Source of Referral	Transfer In
Care Type	Non-Acute Length of Stay	Total Leave Days	ICU Hours	MV Hours	Transfer Out
Same Day Status	Mental Health Legal Status	Inter-Hospital Contracted Patient	Unplanned Theatre Visit During Episode: Yes ☐ No ☐	Provider No. of Hospital Transferred From:	Provider No. of Hospital Transferred To:

I certify the above information is true and correct according to our records for this period of hospitalisation. The hospital authorises the fund or its agent to inspect all records applicable to the patient for the purpose of determining appropriate benefits.

Authorising Hospital Officer's Signature: **Date:** / /

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CODES FOR CLAIM FORM ITEMS*

ADMISSION CODES
1 Admission Claim
2 Continuation Claim
3 Unplanned Re-admission within 28 Days
4 Same Day
5 Transfer from Another Hospital
6 Other Re-admission

ACCOMMODATION CODES
1 Single Room
2 Shared Room
3 Shared Room+
4 Coronary Care
5 Intensive Care
6 Other (eg HDU)
7 Neonatal
8 Nursing Home Type Patient
9 Rehabilitation Program
10 Psychiatric Program
11 Outreach/Hospital in the Home Care

DISCHARGE CODES
1 Discharged
2 Interim Claim
3 Deceased
4 On Leave
5 Transfer to Another Hospital
6 Early Discharge Program

PAYMENT TYPE CODES
1 Per Diem
2 Case Payment
3 Other_____
(Hospital to insert other payment type)

OTHER SERVICES CODES
1 Labour Ward
2 Theatre Fee
3 Pharmaceuticals
4 Nursery Fee
5 Disposables
6 Prostheses
8 Allied Health Services
7 Other

INFANT / NEONATE WEIGHT
The admission weight rounded to the nearest gram.

URGENCY OF ADMISSION CODES
1 Urgency status assigned – emergency
2 Urgency status assigned – elective
3 Urgency status not assigned
9 Not known / not reported

MODE OF SEPARATION CODES
1 Discharge / Transfer to an (other) Acute Hospital
2 Discharge / Transfer to a Nursing Home
3 Discharge / Transfer to an (other) Psychiatric Hospital
4 Discharge / Transfer to Other Health Care Accommodation
5 Statistical Discharge – Type Change
6 Patient Left against Medical Advice
7 Statistical Discharge from Leave
8 Died
9 To Home / Other

SOURCE OF REFERRAL CODES
The facility from which the patient was referred as follows:
0 Born in Hospital
1 Admitted Patient Transferred from Another Hospital
2 Statistical Admission – Type Change
4 From Accident/Emergency
5 From Community Health Service
6 From Outpatients Department
7 From Nursing Home
8 By Outside Medical Practitioner
9 Other

TRANSFER CODES – TRANSFER IN OR TRANSFER OUT
U **Up Transfer:** This / the next Hospital stay is expected to be more resource intensive than the next / previous hospital stay
D **Down Transfer:** This / the next hospital stay is expected to be less resource intensive than the next / previous hospital stay
L **Lateral Transfer:** This / the next hospital stay is expected to be of similar resource intensity as the next / previous hospital stay
X **Unknown**

CARE TYPE CODES
The type of service for which the patient was initially admitted:
10 Acute Care
20 Rehabilitation Care
21 Rehabilitation Care Delivered in a Designated Unit
22 Rehabilitation Care According to a Designated Program
23 Rehabilitation Care is the Principal Clinical Intent
30 Palliative Care
31 Palliative Care Delivered in a Designated Unit
32 Palliative Care According to a Designated Program
33 Palliative Care is the Principal Clinical Intent
40 Geriatric Evaluation and Management
50 Psychogeriatric Care
60 Maintenance Care
70 Newborn Care
80 Other Admitted Patient Care
90 Organ Procurement - Posthumous
100 Hospital Boarder

ICU HOURS
The number of hours spent by the patient in one or more of the following:
ICU; CCU; Neonatal Intensive Care; Paediatric Intensive Care.
This does not include days spent in Special Care Nurseries or High Dependency Units.

MV (MECHANICAL VENTILATION) HOURS
The number of hours (rounded) for which the patient received mechanical ventilation in ICU during the episode.

SAME DAY STATUS CODES
0 Patient with a Valid Arrangement allowing for Overnight Stay for Procedure normally performed on a Same Day Basis. (Please complete Overnight Stay Certification)
1 Same Day Patient
2 Overnight Patient (other than type 0 above)

MENTAL HEALTH LEGAL STATUS CODES
1 Involuntary
2 Voluntary
3 Not permitted to be reported under legislative arrangements in the jurisdiction
8 Not applicable

INTER-HOSPITAL CONTRACTED PATIENT CODES
1 Inter-Hospital contracted patient from public sector
2 Inter-Hospital contracted patient from private sector
3 Other
9 Not reported

* Based on Hospital Casemix Protocol data definitions published by the Australian Government Department of Health & Ageing.

Barcode Area

4. DAY ONLY PROCEDURES AND OVERNIGHT STAY CERTIFICATION

(PLEASE TICK (✓) BELOW)

DATE OF SERVICE: / /

☐ Day Only Procedures – Certification
Certificate for the purpose of section 10, Part 3, Schedule 1, Private Health Insurance (Benefit Requirements) Rules 2010

☐ Overnight Stay Admission – Certification
Certificate for the purpose of section 11, Part 3, Schedule 1, Private Health Insurance (Benefit Requirements) Rules 2010

Note: Overnight Certificate only required when a Band 1 or a non-band specific Type B patient is admitted as an Overnight Stay Patient

I certify that this hospitalisation / overnight stay was necessary because of:

☐ The medical condition of the patient named overleaf, namely...

☐ Other special circumstances, namely...

Please specify medical condition and / or other special circumstances:

Name of medical practitioner providing the professional treatment:

Name of authorised hospital health professional (where applicable):

[Overnight certification may be provided by a professional employed by the hospital who is suitably qualified to do so. (This applies only in the event that the treating practitioner is not physically available to certify the certificate. There is still a requirement for the hospital representative to consult and obtain ratification from the treating practitioner of the need for overnight hospital care)].

Date of Consultation Certifying the Need for Overnight Hospital Care: / /

Time of Consultation (24hr) :

Signature of Treating Practitioner (or Authorised Person where applicable)

Date: / /