Section 12: Fast Cover Medical Authority Form

Complete this form if your claim is due to an accident, illness, disability or death.

The form must be completed by the patient (injured, ill or disabled person) whose illness or injury resulted in this claim or Executor of the Estate in the event of a death.

☐ I authorise Fast Cover or its representatives to obtain from any person or organisation any information regarding treatment for the condition(s) which resulted in this claim. I acknowledge that a photocopy of this authorisation shall be considered as valid as the original.

Claim Number:

Policy Number:

Patients Full Name:

Patients Date of Birth:

Patients Signature:

Executor of the Estates Full Name (if applicable):

Executor of the Estates Signature (if applicable):

Name of Patients Usual Doctor/Dentist in Australia:

Doctor/Dentists Phone Number:

Doctor/Dentists Fax Number:

Doctor/Dentists Email Address:

Doctor/Dentists Postal or Practice Address:

Suburb: State: Postcode:

If your trip was cancelled or postponed before you left, you must have the Medical Certificate in Section 13 completed by the usual treating Doctor or Dentist of the patient (injured, ill or disabled person) **whose illness or injury resulted in this** claim. If we need further information from a Specialist we will let you know.

Please return completed form to Fast Cover

Email Address	claims@fastcover.com.au (Please include claim number in email subject)
Phone Number	1300 409 322
Fax Number	02 8883 7002
Postal Address	Fast Cover Claims PO Box R1384 Royal Exchange NSW 1225

Section 13: Fast Cover Medical Certificate

This medical certificate is to be completed:

- at the claimant's expense
- by the patient's usual Doctor or Dentist in Australia
- for all cases of medical, dental, unexpected expense and cancellation claims resulting from an accident, illness, disability or death.

The medical practitioner is respectfully requested to give as much detail as possible in order for us to assist our client and avoid the necessity of additional enquiries

Claim Number:

Claimants Name:

1. Patients Name: Patients Date of Birth:

2. Are you the Patients usual GP? ☐ Yes ☐ No

2A. If yes, how many years/months?

2B. If no, please give details of the Patients usual GP:

3. What is the precise diagnosis of the injury or illness that led to this claim?

4. Date of onset of injury or illness:

5. Date you were first consulted for this injury or illness:

5A. What test(s) did you prescribe?

5B. Date test(s) prescribed:

5C. Date test(s) performed:

5D. Date results advised to Patient:

6. Was the Patient under the care of any other Doctors, including Specialists? ☐ Yes ☐ No

6A. If yes, please provide the details of the other treating Doctors:

6B. Date first referred to a Specialist:

6C. Name of Specialist/Surgeon:

6D. Phone number of Specialist/Surgeon:

6E. Email of Specialist/Surgeon:

6F. Postal address of Specialist/Surgeon:

7. Have you previously treated or advised this patient in respect of the same illness or injury as described in question 3?

7A. If yes, please provide details below:

7B. If yes to '7' was this illness/injury the same or a similar/related injury? ☐ Yes ☐ No

7C. If yes to '7', please state when you last treated the patient, prior to the occurrence giving rise to this claim, and give details of the treatment and/or medication prescribed:

7D. If yes, was the patient advised to continue this treatment and/or medication:

Until departure on the Trip	☐ Yes ☐ No
Whilst on the Trip?	☐ Yes ☐ No

8. Did the Patient travel against your advice?	☐ Yes ☐ No
9. Are you prepared to certify that the Claimant(s) were required to cancel their travel arrangements solely due to the condition described in question 3?	☐ Yes ☐ No
10. Please attach your consultation notes relevant to this condition described in question 3	

☐ I certify that the Statements contained in this medical certificate are true and correct.

Doctors Name:

Doctors Signature:

Qualification:

Phone:

Fax:

Email:

Address:

Suburb: State: Postcode:

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