Liberty Health Cover
Oncology Application Form

LIBERTY

FOR OFFICIAL USE ONLY	Member/ policy number	

Important: please read the following before completing this application form
- Please write clearly using capital and block letters.
- Please submit your completed form to our Liberty Health Cover in-country office.

1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Please complete in block capitals

Last name

First names | Title

Medical Insurer

Membership/ policy number

ID/ Passport number

2. GENERAL PATIENT INFORMATION

Please complete in block capitals

Patient's last name

Patient's first names

Patient dependant code | Gender M F

Date of birth Y Y Y Y M M D D

Home telephone (please include country and area code) +

Mobile (please include country and area code) +

Fax (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

3. DOCTOR AND PROVIDER DETAILS

Please complete in block capitals

Treating doctor's first name

Treating doctor's last name

Speciality

Practice/Registration No.

Hospital name

Hospital Practice No.

Work telephone (please include country and area code) +

Fax (please include country and area code) +

Mobile (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

PATIENT HISTORY

Please complete in block capitals

Primary Diagnosis

ICD-10 code

Primary site

Date first diagnosed Y Y Y Y M M D D

Secondary Diagnosis

ICD-10 code

Secondary site

Date of second diagnosis Y Y Y Y M M D D

Performance Status

Grade

Stage: T N M

ECOG scale

Karnofsky score

Metastases

Bone Date Y Y Y Y M M D D

Brain Date Y Y Y Y M M D D

Liver Date Y Y Y Y M M D D

Lung Date Y Y Y Y M M D D

Other Date Y Y Y Y M M D D

If other, please specify

Receptors

Co-morbidities 1 2

3 4

Prostate

Volume

Gleason scale

PSA

Stage

Other

TREATMENT HISTORY

Full Clinical History

Start Date	Description	Medication	Outcome	Comments
Y Y Y Y M M D D				
Y Y Y Y M M D D				
Y Y Y Y M M D D				
Y Y Y Y M M D D				

PROPOSED TREATMENT PLAN

Chemotherapy Drugs

Product Name	Active Ingredients	Dose	Frecuency	No. of Cycles	Total Cost

Supported Drugs

Product Name	Active Ingredients	Dose	Frecuency	No. of Cycles	Total Cost

Radiotherapy

Treating doctor

Professional practice No.

Name of Hospital

Technical/Hospital No.

Start date Y Y Y Y M M D D End date Y Y Y Y M M D D

Area to be irradiated

Duration (in weeks)

	Tariff codes	Tariff costs		Tariff codes	Tariff costs
1			5		
2			6		
3			8		
4			9		
5			10		

Application Check List (Mark with a cross the documents that are attached for submission)

- ☐ Completed Application Form
- ☐ Histology Results
- ☐ Pathological results indicating tumor markers (if applicable)
- ☐ Radiological Investigation Results
- ☐ Additional Clinical Motivation, including relevant supportive clinical literature, may be required for requests outisde of Liberty Health's funding protocols

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Having conducted a personal medical examination, I certify that the particulars are, to the best of my knowledge and belief, true and accurate . I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

Doctor's last name

Doctor's first name

Doctor's signature Date Y Y Y Y M M D D

4. PATIENT'S DECLARATION

I hereby declare that the information in this form is true and correct. I am aware that the Insurer may request medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires.

In order to fully assess this application for benefits, I hereby give my consent for the Insurer to obtain this information. I understand that this application is subject to the Liberty Health Cover Policy Conditions and benefits.

Patient's signature Date Y Y Y Y M M D D