

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 (e.g. yoga, yogalates, gym, pilates, tai chi).

***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: Member's details

Title	Surname	Gender
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F
Given name	Date of birth	
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Home address		
<input type="text"/>		
State		Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Work telephone number	Home telephone number	Mobile number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address		
<input type="text"/>		

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

Patient's name		
<input type="text"/>		
Practitioner's name		
<input type="text"/>		
Provider number	Telephone number including area code	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Please indicate the medical condition that this program is addressing		
<input type="text"/>		
Please indicate the program you're recommending to improve or address the patient's medical condition		
<input type="text"/>		
Start date of program/treatment	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Please indicate the length of time (months) recommended for this course of treatment		
<input type="text"/>		
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	Date signed	
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	