

Health Management Program – Supporting Documentation

PLEASE NOTE - benefits are payable for gym membership fees (visits) where:

- The membership of a gym or visits to a gym are required to enable the nib customer to undertake a health management program for the treatment of a health related condition; and
- The health management program has been recommended to the customer by an nib recognised provider who has the customer under their care for the treatment of the health related condition; and
- All supporting documentation required by nib in relation to the health management program has been completed in the manner required by nib; and
- The gym is recognised by nib.

This section to be completed by the patient

nib policy number Patient's name

I declare that I am undertaking a 'health management program' for treatment of a health related condition.

I declare that all the information I have given on this form is true. To allow nib to process my claim, I allow nib to: use information on this form; use information I have previously given nib; contact my previous fund, treating health professional and/or provider of the services for which I'm claiming to obtain information and/or personal and medical records to verify any aspect of the claim.

I acknowledge that nib may use the information on this claim form to assess and process this claim, or for other purposes related to this claim as outlined in nib's Privacy Policy. I confirm the services submitted on this claim form were performed by the providers, and received by the persons named on this form. I declare these services cannot be claimed from worker's compensation, a third party or any other source.

Patient's signature Date

This section to be completed by the health professional recommending the program.

Type of health professional
(ie: physiotherapist or medical practitioner)

Health professional's name

Health professional's number
(if applicable i.e. Medicare Provider No.)

Name of gym

Health management program period from to
(maximum 12 months)

Providers Stamp

I acknowledge that I have recommended to the above patient, who is under my care, a 'health management program' at the above gym for the period stated, for the treatment of a health related condition.

Health professional's signature Date