Insulin Pump Request

- This form is to be used when requesting consideration of funding for an insulin pump.
- The request is to be submitted to the fund prior to the supply of the insulin pump.
- The fund will endeovour to respond to the request by the requested time.
- The form is to be completed in full and must be legible.

Attention: Claims Department, Health Insurance Fund of WA, 60 Stirling Street PERTH WA 6001. Phone: 1300 13 40 60. Fax: 08 9328 3345

Hospital:_____ **Contact Name:** _____

Telephone:_____ **Fax:**_____

Member Number: _____

Member Name: _____

Address: _____

_____

Patient Name: _____
Date of Birth: _____

Description and model number/ Billing code: _____

Cost: _____

Date of Procedure:_____

Initial Insulin Pump request:

Has the patient been diagnosed with Type 1 diabetes? Yes ☐ No ☐

Continuous subcutaneous insulin therapy has been trialled and established as the most appropriate form of treatment for this patient? Yes ☐ No ☐

Is the insulin pump to be provided as part of an admitted medically necessary hospital episode? Yes ☐ No ☐

Clinician Declaration:

I declare that the use of the insulin pump is recommended by an Endrocrinologist, specialist clinician (specialising in the management of Diabetes) or a Credentialed Diabetes Educator – Registered Nurse (CRDE_RN).

The patient is aware of the out-of- pocket costs related to consumables.

Authorising Name: _____

Authorising Signature:_____**Date**_____

Replacement Pump Request:

Clinical Declaration:

I declare that the recommendation for the replacement pump has originated from an Endocrinologist, specialist clinician (specialising in the management of Diabetes) or a Credential Diabetes Educator – Registered Nurse (CDRE_RN). This recommendation includes a reassessment of the clinical need for the continuing use of an insulin pump.

The patient is aware of the out-of -pocket costs related to consumables.

Authorising Name: _____

Authorising Signature:_____**Date**_____

Member declaration:

I authorise the provider of the treatment or service to provide to HIF all information including clinical records or details if required.

I declare that the answers provided on this form and any attached documents are true and correct.

Member Signature: _____**Date:**_____