Exercise Class Approval Form

Exercise classes are claimable if your policy includes benefits for Health Management services. The exercise class must have been recommended by a health care professional, such as your GP to manage a specific health condition(s) and must be conducted by a personal trainer. Please note: This **does not** cover exercise based therapies such as yoga, pilates and tai chi.
This form must be completed by a Health Provider stating what condition the exercise classes are intended to manage.
A Health Provider for the purposes of this form means a General Practitioner (GP), Exercise Physiologist, Physiotherapist, Osteopath, Chiropractor, Occupational Therapist, Diabetes Educator or Aboriginal Health Worker.

To be eligible to receive any benefits for Exercise Classes:

1. Print this Exercise Class Approval Form
2. Take it to your Health Provider and have them complete this form
3. Submit this form by email at frank@frankhealthinsurance.com.au
4. Paid invoice must be supplied at the time of claim. Benefits will not be paid for services provided before the date noted on this form

Patient Details

Who is this claim for?

Member Number

First name

Surname

Health Provider Details

This section must be completed by the Health Provider recommending the exercise class

Name

Provider Number

Speciality

Address

Suburb

State

Postcode

Provider Phone Number

Health Condition details

What are these classes or courses aimed to managed?

- ☐ Arthritis
- ☐ Asthma
- ☐ Body Mass Index (BMI) over 26 for adult or unhealthy for children
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Muscular skeletal disorder
- ☐ Pregnancy
- ☐ Other - Please detail below

Duration of Program

I recommend this patient completes the program over;

_____ Weeks / Months (circle appropriate period)

Please note: This duration should not exceed 12 months

Declaration by Health Provider

I confirm that this patient is under my care, and as part of their treatment I recommends the above program.
I declare that the benefit sought by the member is intended to manage a specific health condition(s) that I have identified and that all of the information contained in this form is true and correct.

Health Provider's Signature

Date: / /