



Medicare claim



Instructions: Only use this form when claiming by mail or Medicare drop box or for unpaid accounts or when authorising an agent to claim on your behalf.

You must attach **original** itemised accounts and receipts to this form.

Send the completed form to Medicare Australia, GPO Box 9822 in your capital city or place in the 'drop box' at your local Medicare office.

Patient's details—The patient is the person who received the medical and/or dental service

1 Patient's Medicare card number - -

| Ref no. | Patient's first given name | Services provided by (e.g. Dr A P Jones) | Account paid in full? Yes <input type="checkbox"/> No <input type="checkbox"/> |
|---------|----------------------------|--|---|
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Claimant's details—The claimant is the person who paid for, or is likely to pay for, the medical and/or dental expenses. Medicare benefits will be paid to this person

2 Is the claimant's Medicare card number the same as the patient's Medicare card number?
Yes

No Claimant's Medicare card number - - Ref no.

3 Dr Mr Mrs Miss Ms Other

Family name

First given name

4 Date of birth / /

5 Sex Male Female

6 Business name—for non-compensation claims where the claimant is an organisation or business (e.g. a nursing home) that has incurred the expenses on behalf of the patient.

7 Postal Address
 Postcode

Do you want this recorded as your permanent postal address? Yes No

8 Daytime phone number

9 Email (optional) @

10 Was the patient an in-patient of a hospital or approved day facility?
Yes Date of: Admission / / Discharge / /
No

Payment of benefits—It is important you provide your bank account details.

11 Have you previously supplied your bank account details? Yes No

12 To supply or update your bank account details, please provide the following information. These details will be used for future payments.

Payment cannot be made to credit card, loan or mortgage accounts.

Name of bank, building society or credit union

Branch where the account is held

Branch number (BSB) -

Account number (this may not be the card number)

Account held in the name(s) of

13 If you want a statement of benefit posted, please tick this box:

If your claim includes in-hospital services, we will automatically issue a statement of benefit to you.

14 Is your family registered for the Medicare Safety Net?

Yes

No or not sure

For information about the Medicare Safety Net or how to register, call **132 011** (call charges may apply) or go to www.medicareaustralia.gov.au

15 Do you want to authorise another person (e.g. an agent) to collect benefits on your behalf?
We will ask your agent to provide satisfactory personal identification before collecting benefits on your behalf.

Yes Please give details of your agent

| | |
|-------------------|-------------------------------|
| Full name | <input type="text"/> |
| Permanent address | <input type="text"/> |
| | Postcode <input type="text"/> |
| Agent's signature | <input type="text"/> |

No

Claimant's declaration

16 I hereby claim benefits for the professional service to which this claim relates and I understand that:

- It is an offence under the *Health Insurance Act 1973* and the *Dental Benefits Act 2008* to make a false statement relating to Medicare benefits.

I declare that:

- I have paid for, or am liable to pay, the expenses for these services
- the services were not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with the patient's employment
- the services were not provided by or on behalf of the Australian Government, a state, territory or a local governing body or an authority established by a law of the Australian Government, state or territory
- I have not claimed for dental expenses through private health insurance
- the information on this form is correct.

Claimant's signature

Date

Privacy note – The information on this form will be used to assess a Medicare and/or dental benefit payable for the services rendered and may be used to update enrolment records. The EFT details collected will be stored and used for any future payments to you from programs administered by Medicare Australia. The collection of this information is authorised by the *Health Insurance Act 1973* and the *Dental Benefits Act 2008*. This information may be disclosed to the Department of Health and Ageing, Centrelink, other relevant agencies or to a person in the medical and/or dental practice associated with this claim or as authorised or required by law. Patient names and addresses may be disclosed to financial institutions when the claim is paid. Information about medical and/or dental expenses for people under the age of 18 may also be disclosed to adults on the same Medicare card, through taxation statements.

Organ Donor Register (optional)

Australian
organ donor
register

1 Your Medicare card number - - Ref no.

2 Your details Family name

First given name

Date of birth / / Sex Male Female

3 I wish to register my consent to donate the following organs and/or tissue for transplantation, in the event of my death. Tick 'All' or as many as apply

All Bone tissue Eye tissue Heart

Heart valves Kidneys Liver

Lungs Pancreas Skin tissue

4 I wish to register my decision **not to be** an organ and/or tissue donor

If you would like another form allowing up to two people who live at the same address to register, call **1800 777 203** (call charges may apply) or go to **www.medicareaustralia.gov.au**

5 Declaration

- I give permission for the details I have provided to be actioned on the Australian Organ Donor Register.
- I have discussed this decision with my family, partner or friend.
- I am aware that I can change these details at any time.

Your signature

Date

When we have processed your registration we will send a confirmation letter to your postal address recorded by Medicare Australia.

For more information

Call Medicare Australia on **132 011** (call charges apply), the Australian Organ Donor Register on **1800 777 203** (call charges may apply) or go to **www.medicareaustralia.gov.au/organ**

Privacy note – The information on this form will be used to register you on the Australian Organ Donor Register (the Donor Register) or to update your details on the register. The collection of this information is authorised by the *Medicare Australia Act 1973*. This information may be disclosed to authorised personnel in the organ and tissue donation network or as authorised or required by law.