

**Use our online services**

You can apply online. This means you do not have to complete this paper form. You can register to use our online services at [iptaas.enable.health.nsw.gov.au](http://iptaas.enable.health.nsw.gov.au)

**When to use this form**

You require a separate application for each different practitioner or health service you travel to.

You should use this form if:

- this is the first time you have applied for assistance from IPTAAS to travel to this practitioner or health service
- you have not submitted a referral for this practitioner or health service in the last **two years**
- your personal details have changed since the last time you submitted an application and you have not updated them using our online services

**What else you may need to provide**

We may require documentation to support your application. You may need to provide:

- invoices for travel and accommodation costs
- evidence that you have attended your appointment

**Filling in this form**

- please use black or blue pen
- print in BLOCK LETTERS
- mark boxes like this  with a ✓ or X
- where you see a box like this  **Go to question...** skip to the question number shown. You do not need to answer the questions in between.

**For more information**

Go to our website [www.iptaas.health.nsw.gov.au](http://www.iptaas.health.nsw.gov.au) or call us on **1800 IPTAAS (1800 478 227)**.

**Applications must be submitted within 12 months of your discharge or appointment end date.**

**Part A. Eligibility details**

Please read before answering question 1.

Patients receiving financial assistance for travel and accommodation from other services are not eligible for IPTAAS. If you are receiving assistance from another government or third party service do not complete this form.

**1. Have you received, or are you eligible for financial assistance for travel and accommodation from**

An Australian federal, state or territory government travel scheme, other than IPTAAS?

No  Yes

Department of veterans' affairs?

No  Yes

Workers compensation?

No  Yes

Motor vehicle insurance?

No  Yes

**Part B. Patient details**

**2. Patient ID (if known)**

**3. Your name**

Title	Given name	Middle name	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**4. Your date of birth**

**5. Your gender**

Male  Female  Other

**6. Your Medicare card number**

<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"/>	Line no. <input type="text"/>
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**7. Do you have a concession card issued by Centrelink or DVA?**

No **Go to question 8**

Yes Give details Concession card number  Concession card expiry date

**8. Your residential address**

<input type="text"/>	
State	Postcode

**9. Your postal address**

(if different to residential)

<input type="text"/>	
State	Postcode

**10. Your contact details**

Email	Phone number	Mobile number
<input type="text"/>	( )	<input type="text"/>

What is your preferred contact method?  Post  Email  Phone  Mobile

**11. Are you of Aboriginal or Torres Strait Islander Australian descent?**

No  Yes

**12. Your authorised contact**

(optional)

Name	Relationship to you
<input type="text"/>	<input type="text"/>

Phone number	Mobile number
( )	<input type="text"/>

## Part C. Referral details

Please read before completing Part C. Referral details.

**Part C: Referral details** is only required if this is the first time you have applied for assistance from IPTAAS to travel to this practitioner or health service, or you have not submitted a referral to this practitioner or health service in the last two years.

If required, **Part C: Referral details** is to be completed by your referring practitioner or their authorised representative.

**13. Referring practitioner details** Full name  Phone number  (  )

**14. Treatment details** Name of practitioner or health service you referred the patient to

Treatment location  Type of treatment referred for

Is the practitioner or health service the nearest to the patient's residence?

Yes **Go to question 15**

No Give details below

Why was the patient not referred to the nearest practitioner or health service?

  

**15. Referring practitioner declaration (to be completed by the referring practitioner or their authorised representative)**

Name  Position

**I declare that:**

- the information provided in Part C of this form is complete and correct

**I understand that:**

- giving false or misleading information is an offence

Signature  Date

## Part D. Air travel details

Please read before answering question 16.

If you need to travel by commercial air, you should get an air approval. Your practitioner or their authorised representative must contact IPTAAS to get an air approval. You will only get an air approval if you meet the air approval criteria.

**16. What is your air approval code?**

## Part E. Treatment details

**17. What type of treatment did you travel for?** (Select one and answer applicable questions)

**Specialist**

Was your treatment part of a clinical trial?  No  Yes

Was your travel for health screening?  No  Yes

**Allied Health**

**Dental**

Do you have a cleft palate?  No  Yes

Did you have surgery under general anesthesia?  No  Yes

**Prosthetic/Orthotic**

Did you travel to a public hospital or public clinic?  No  Yes

**18. Treatment details**

Name of specialist, allied health clinic, dentist or prosthetist/orthotist  Phone number   
 ( )

Medicare provider number (not applicable to allied health or prosthetic/orthotic treatment)

OPTIONAL: AHPRA registration number (if known) (not applicable to allied health or prosthetic/orthotic treatment)

Treatment address

State  Postcode

**19. Were you hospitalised?**

Yes Give details Admission date  Discharge date   
 D D/M M/Y Y Y Y D D/M M/Y Y Y Y

No If no, what was your appointment date? Start date  End date (if different to start)   
 D D/M M/Y Y Y Y D D/M M/Y Y Y Y

**20. Did you need to stay before or after the hospitalisation or appointment dates?**

No **Go to question 21**

Yes Give details  nights before and/or  nights after

**Please read before completing question 21.**

**Question 21: Practitioner or health service declaration** is optional unless you are staying more than two nights before or after your appointment/hospitalisation dates.  
 If completed, **Question 21: Practitioner or health service declaration** is to be completed by your treating practitioner or health service, or their authorised representative.

**21. Practitioner or health service declaration (to be completed by the treating practitioner, health service or their authorised representative)**

Name  Position

**I declare that:**

- the information provided in Part E of this form is complete and correct

**I understand that:**

- giving false or misleading information is an offence

Signature  Date   
 D D/M M/Y Y Y Y

**Part F. Payment details**

**22. Your bank account details**

Account name

BSB number  Account number

**23. Would you like a third party organisation to receive part of your subsidy?**

- No **Go to question 24**

- Yes Give details below

What part of your subsidy would you like the third party organisation to receive?  Travel  Accommodation  Both

**Third party organisation details**

Name  Phone number   
 ( )

ABN  Supplier number (if known)

## Part G. Travel and accommodation details

### Please read before completing Part G. Travel and accommodation details.

This form is for **one trip** from your residence to the health service and return. If you would like to claim in transit travel or travel and/or accommodation for more than one trip you should complete and attach **Form 2. Travel and accommodation supplement** to this application.

You need to provide invoices for travel and accommodation costs (except private vehicle travel and private accommodation) with your application.

#### 24. Were you accompanied by an escort during travel or accommodation?

No **Go to question 26**

Yes Give details Your escort's full name

#### 25. Does your escort have a concession card issued by Centrelink or DVA?

No **Go to question 26**

Yes Give details Your escort's concession card number  Your escort's concession card expiry date

#### 26. Your travel details

<b>Travel dates</b>	Departure date <input type="text" value="D D/M M/Y Y Y Y"/>	Return date <input type="text" value="D D/M M/Y Y Y Y"/>		
<b>Mode of travel</b> (Check applicable box)	Forward Patient	Escort	Return Patient	Escort
Private vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Commercial air	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taxi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### 27. Are you claiming accommodation?

No **Go to question 29**

Yes Give details Check in date  Check out date

#### 28. What type of accommodation did you stay in?

More information about accommodation types is available on our website.  Private  For Profit  Not for profit

## Part H. Patient declaration and privacy

The information contained in this application is protected by law from unauthorised access and misuse. The information will only be accessed by health service staff directly involved in providing services to the applicant, or with other lawful excuse. You can view our privacy statement on our website.

#### 29. Patient declaration (to be completed by you or your parent, guardian, escort or authorised contact)

##### I declare that:

- The information I have provided in this form is complete and correct and the documents provided are genuine
- If applicable, I am authorised to complete this application on behalf of the patient

##### I understand that:

- NSW Health may make relevant enquiries to assess this application and make sure I receive the correct subsidy
- I may be audited. If my practitioner or health service did not complete question 21 of this form I am required to keep evidence to prove I attended my appointment for **two years**
- Giving false or misleading information is an offence

Your name

Your signature  Date

#### Submitting your form

Check that all required questions are answered and that the form is signed and dated. You can submit this form and supporting documentation to your local IPTAAS office by email, post or fax. Please ensure forms submitted by post are addressed to IPTAAS.

##### Hunter New England – Tamworth

**Post:** Locked Bag 9783, Tamworth NEMSC NSW 2348

**Email:** HNELHD-IPTAAS@health.nsw.gov.au

**Fax:** (02) 6766 4576

##### Northern NSW, Mid North Coast – Port Macquarie

**Post:** PO Box 126, Port Macquarie NSW 2444

**Email:** MNCLHD-TFH-IPTAAS@health.nsw.gov.au

**Fax:** (02) 5524 2996

##### Far West – Broken Hill

**Post:** PO Box 457, Broken Hill NSW 2880

**Email:** FWLHD-IPTAAS@health.nsw.gov.au

**Fax:** (08) 8080 1695

##### All other

**Post:** Locked Bag 5270, Parramatta NSW 2124

**Email:** IPTAAS@health.nsw.gov.au

You may be able to provide your form in person at one of our offices. Contact IPTAAS for more information about over the counter services.