

Instructions: Only use this form when claiming by mail, service centre drop box, for unpaid accounts or when authorising an agent to receive benefits on your behalf (agents must be present at one of our service centres).

Staple the **original** itemised accounts **and** receipts to this form.

Send the completed form to **the Department of Human Services, GPO Box 9822** in your capital city or place in the 'drop box' at one of our service centres.

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

1 Patient's Medicare card number - - Ref no.

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 also the patient?

No

Claimant's Medicare card number

- - Ref no.

Yes

Go to 7

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—Do you want to use the address you have recorded with us?

No/unsure please provide address

Postcode

Yes **Go to 8**

Do you want this recorded as your permanent postal address for everyone on your Medicare card?

No Yes

8 Email (optional)

9 Daytime phone number

()

Service details – The medical services you are claiming benefit for.

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

11 Was the patient an in-patient of a hospital or approved day facility?

No

Yes

Date of admission

/ /

Date of discharge

/ /

Payment of benefits—It is important the claimant provides their bank account details.

12 Have you previously supplied your bank account details? No Yes **Go to 14**

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

All payments are made through Electronic Funds Transfer(EFT). Medicare benefits **cannot** be paid via electronic funds transfer (EFT) if the nominated account has restrictions on EFT deposits, is a credit card, or an overseas account.

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

14 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.

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 receiving benefits on your behalf. Your Medicare benefit will be paid via Credit EFTPOS into your agent's bank account. Your agent will be required to hold a debit card in order to complete the transaction.

No

Yes

Please give details of your agent

Full name

Permanent address

Postcode

I declare that:

- I have read and understood the Privacy notice contained in this form.

Agent's signature

Medicare Safety Net

The Medicare Safety Net provides families and individuals with financial assistance for high out-of-pocket costs for out-of-hospital Medicare Benefits Schedule services. For information or to register, go to our website humanservices.gov.au/safetynet or call **132 011**.

Note: Call charges apply. Calls from mobile phones may be charged at a higher rate.

Claimant's declaration

16 I hereby claim benefits for the professional service(s) to which this claim relates and 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, and
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Claimant's signature

Date

Privacy notice – Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim. Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law. You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy, at humanservices.gov.au/privacy or by requesting a copy from the department.

Australian Organ Donor Register (optional)

1 Your Medicare card number - - Ref no.

2 Your details Family name

First given name

Permanent postal address

Postcode

Note: This address will be used to update the Medicare record for everyone on your Medicare card.

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

5 Organ donor declaration

I declare that:

- 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 my donation decision details at any time.
- I have read and understood the Privacy notice contained in this form

Your signature

Date

For more information

For more information, go to our website humanservices.gov.au/organdonor or call the Australian Organ Donor Register on **1800 777 203**.

Note: Call charges apply from mobile phones.