

Claim Form

If this claim is the first visit to your Specialist / Prothotist / Orthotist or eligible Allied Health Professional, please also complete an IPTAAS Doctor Referral form.

PART 1 – PATIENT AND ESCORT DETAILS

1.1 ELIGIBILITY DETAILS

Have you claimed, or are you entitled to claim, travel and/or accommodation benefits from any of the following:

1. Any Australian, State or Territory government scheme other than IPTAAS?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	If you are uncertain about your eligibility please contact your nearest IPTAAS Office to confirm
2. As part of a Workers Compensation claim?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
3. As part of any insurance claim?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
4. Do you have a Veterans' Affairs (DVA) Gold Card?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	

1.2 PATIENT DETAILS

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

Residential address	Postal address
<input type="text"/>	<input type="text"/>
Postcode	Postcode
<input type="text"/>	<input type="text"/>

Daytime phone number	Mobile number	Email address
<input type="text"/>	<input type="text"/>	<input type="text"/>

Preferred contact method	Drivers licence number (if applicable)
Email <input type="checkbox"/> Mail <input type="checkbox"/> Daytime phone <input type="checkbox"/> Mobile phone <input type="checkbox"/>	<input type="text"/>

Medicare card details	Are you Aboriginal/Torres Strait Islander?
Card number <input type="text"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Position on card <input type="text"/>	

Alternate contact person details
Name <input type="text"/>
Phone number <input type="text"/>

1.3 ESCORT DETAILS (if applicable)

An escort is a person who, for medical reasons, is required to accompany an IPTAAS patient while travelling to specialist medical treatment

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

1.4 CONCESSION DETAILS AND CENTRELINK CONSENT

Do you or your escort have a Pension or Health Care Card?

No <input type="checkbox"/>	Go to Section 1.5 on page 2
Yes <input type="checkbox"/>	Give details on page 2

I/We authorise:

- EnableNSW to use Centrelink Confirmation eServices to perform a Centrelink/DVA enquiry of my Centrelink or Department of Veterans' Affairs Customer details and concession card status in order to enable the business to determine if I qualify for a concession, rebate or service.
- The Australian Government Department of Human Services (DHS) to provide the results of that enquiry to EnableNSW.

I understand that:

- DHS will use information I have provided to EnableNSW to confirm my eligibility for EnableNSW programs and services and will disclose to EnableNSW personal information including my name, address, payment and concession card type and status.
- This consent, once signed, remains valid while I am a customer of EnableNSW unless I withdraw it by contacting EnableNSW or DHS.
- I can obtain proof of my circumstances/details from DHS and provide it to EnableNSW so that my eligibility for EnableNSW programs and services can be determined.
- If I withdraw my consent or do not alternatively provide proof of my circumstances/details, I may not be eligible for programs and services provided by EnableNSW.

Details about the Centrelink Confirmation eServices are available on Centrelink's website.

If you do not wish to authorise EnableNSW to confirm the current status of your Commonwealth Benefit and other details as they pertain to your concessional entitlement, **please attach a photocopy of your pension card.**

Note: A personal contribution of \$30.00 will be deducted from this claim if you are **not** a Pension or Health Care Card holder.

Patient name		Date of birth	/	/
--------------	--	---------------	---	---

1.4 CONCESSION DETAILS AND CENTRELINK CONSENT *continued*

Patient

Centrelink benefit number	Expiry date
<input type="text"/>	<input type="text"/>
Type of benefit	
<input type="text"/>	

Patient's Signature	Date
<input type="text"/>	<input type="text"/>

Escort

Centrelink benefit number	Expiry date
<input type="text"/>	<input type="text"/>
Type of benefit	
<input type="text"/>	

Escort's Signature	Date
<input type="text"/>	<input type="text"/>

1.5 BANK ACCOUNT DETAILS FOR CLAIM PAYMENT

Give details of the bank account you want your IPTAAS payments made to. Reimbursements will be made by Electronic Funds Transfer (EFT). If the details provided are incorrect, your payment will be delayed.

Account name	Name of bank, building society or credit union
<input type="text"/>	<input type="text"/>
BSB number	Account number
<input type="text"/>	<input type="text"/>
	Email address for payment notice <i>(if different to that provided in 1.2)</i>
	<input type="text"/>

Should any part of this reimbursement be paid to another organisation or charity?

No Yes

1.6 THIRD PARTY PAYMENT DETAILS – *Required if payment is to be made to a separate organisation*

Organisation name	Vendor number <i>(if known)</i>	Phone number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Which portion of the claim would you like paid to another organisation?

Travel Accommodation Specify amount to be paid \$

1.7 BULK BILL ACCOMMODATION DETAILS *(if applicable)*

Name of accommodation provider	Contact person	
<input type="text"/>	<input type="text"/>	
Phone number	Fax number	
<input type="text"/>	<input type="text"/>	
	Email address	
	<input type="text"/>	
Specialist name	Place of treatment	Accommodation start date
<input type="text"/>	<input type="text"/>	<input type="text"/>

TERMS AND CONDITIONS

- The patient must meet the eligibility criteria for IPTAAS.
- The patient must stay for a minimum of 3 consecutive nights to be eligible for bulk billing
- It is the responsibility of the accommodation provider to organise payment directly with the patient for any additional costs incurred outside of the IPTAAS guidelines
- Before the patient leaves the accommodation facility, Parts 2 and 3 of the IPTAAS Claim form is required, along with an accommodation invoice and any other claimable receipts.
- Invoices must include the conditional approval number, along with both the patient & escort name. Failure to do this may lead to non-payment of your invoice
- Any additional fees (e.g. late check-out) are subject to approval by IPTAAS.

Note: A personal contribution of \$30 will be deducted from the total benefits payable for each return journey or weekly subsidy if claiming under the 200km per week cumulative distance criterion (not applicable to pensioners and Health Care Card holders). Contributions will be capped at four co payments each financial year. In cases where a personal contribution cannot be deducted from the claimant's travel entitlement the contribution is deducted from the accommodation entitlement and payment arrangements must be made between the service provider and the patient. No benefit is payable when the patient is on leave during the course of their treatment.

AUTHORISATION

Patient/Guardian

I have read and understood the terms of this bulk billing conditional approval and agree to meet all accommodation costs if I do not comply with the above conditions.

Signature of Patient/Guardian	Date
<input type="text"/>	<input type="text"/>

Accommodation Provider

I have read and understood the terms of this bulk billing conditional approval. I understand that it is the responsibility of the accommodation provider to seek payment of the accommodation costs from the claimant and therefore should assist the patient/claimant to complete the bulk billing application form where possible.

Signature of Accommodation Provider	Date
<input type="text"/>	<input type="text"/>

Patient name		Date of birth	/	/
--------------	--	---------------	---	---

PART 2 – TRAVEL AND ACCOMMODATION DETAILS

2.1 TRAVEL DETAILS

Use the following codes to help give details of your travel below

People travelling	Trip type	Transport type					
P = Patient E = Escort P/E = Patient and Escort	O = One way R = Return	A = Ambulance AA = Approved Air	B = Bus/Coach C = Community Transport	F = Ferry P = Private car	R = Rail T = Taxi	UA = Unapproved Air	

Journey dates		Where was treatment received? <i>Specify address where treatment was received</i>	People travelling	Trip type	Transport type	Treatment date(s)	
Start	/ /	-----				Start	/ /
End	/ /					End	/ /
Start	/ /	-----				Start	/ /
End	/ /					End	/ /

 Copies of receipts and/or tax invoices for travel must be lodged with this claim. Scanned copies or clear photos of receipts can be emailed to IPTAAS with your claim forms. Food and fuel receipts are not required


Air approval number

Subsequent visits to the same specialist can be claimed by submitting an IPTAAS Travel Diary form signed by the specialist or authorised representative, together with copies of all receipts for travel by public transportation or accommodation.

2.2 ACCOMMODATION DETAILS

Give details of your accommodation – See the IPTAAS Information Sheets if you require more information about accommodation types

Was patient hospitalised?	Hospital admission date	Hospital discharge date	Accommodation type	Accommodation dates	
				Start date	End date
No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /	/ /	Private <input type="checkbox"/> For profit <input type="checkbox"/> Not for profit <input type="checkbox"/>	/ /	/ /
No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /	/ /	Private <input type="checkbox"/> For profit <input type="checkbox"/> Not for profit <input type="checkbox"/>	/ /	/ /
No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /	/ /	Private <input type="checkbox"/> For profit <input type="checkbox"/> Not for profit <input type="checkbox"/>	/ /	/ /
No <input type="checkbox"/> Yes <input type="checkbox"/>	/ /	/ /	Private <input type="checkbox"/> For profit <input type="checkbox"/> Not for profit <input type="checkbox"/>	/ /	/ /

 Copies of receipts and/or tax invoices for accommodation must be lodged with this claim. Scanned copies or clear photos of receipts can be emailed to IPTAAS with your claim forms.

Name of accommodation facility

Address of facility

Postcode

2.3 DECLARATION BY PATIENT OR GUARDIAN

I certify the information in this form is correct, the expenditure shown in Part 2 was actually incurred and benefits relating to that expenditure have not been received nor are claimable from another source, including private health funds. I hereby consent to NSW Health obtaining further information from referring medical practitioners, treating specialists, other health care professionals and travel/accommodation providers where it is required to process this application.

I understand that personal contribution of \$30 will be deducted from the total benefits payable for each return journey or weekly subsidy if claiming under the 200km per week cumulative distance criterion (not applicable to pensioners and Health Care Card holders). Contributions will be capped at four co payments each financial year.

Privacy Note: 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.

Signature

X

Date

Patient name		Date of birth	/	/
--------------	--	---------------	---	---

PART 3 – SPECIALIST AND TREATMENT DETAILS (to be completed by the specialist or their authorised representative)

3.1 SPECIALIST / PROSTHETIST / ORTHOTIST / APPROVED ALLIED HEALTH CLINIC DETAILS

Please see our website www.iptaas.health.nsw.gov.au for a list of approved Allied Health Clinics

Name of Specialist, Prosthetist, Orthotist or Approved Allied Health Clinic	Contact phone number	
Address of treatment/consultation		
	Postcode	
Email address	Specialist provider number (if applicable)	MBS number/service (if applicable)

3.2 TREATMENT / CONSULTATION DETAILS

Treatment/Consultation dates	What type of treatment is the referral for?	Patient has a cleft lip/palate?
From / / To / /		No <input type="checkbox"/> Yes <input type="checkbox"/>
Was hospitalisation necessary?		
No <input type="checkbox"/> Yes <input type="checkbox"/> Give details below		
Hospital address		Postcode
In hospital from / /	In hospital to / /	Is it medically necessary for the patient to remain near the location outside these dates?
		No <input type="checkbox"/> Yes <input type="checkbox"/> How many nights? <input type="text"/>

3.3 ELIGIBILITY FOR AN ESCORT

An escort is a person who, for medical reasons, is required to accompany an IPTAAS patient while travelling to specialist medical treatment. Patients under the age of 17 years are automatically entitled to one escort/carer.

Does the patient require an escort/carer?

During travel	No <input type="checkbox"/> Yes <input type="checkbox"/>	If 'Yes', give details below of the medical reason(s) why an escort/carer is required to travel and/or remain with the patient during specialist treatment
During treatment	No <input type="checkbox"/> Yes <input type="checkbox"/>	

Specify the medical reason(s) why an escort/carer is required to travel and/or remain with the patient during specialist treatment

3.4 AIR TRAVEL DETAILS (if required)


If air travel is necessary for medical reasons, the medical practitioner must obtain approval by calling the local IPTAAS office before each journey.

Does the medical condition of the patient warrant air travel?	Prior approval number
Forward travel No <input type="checkbox"/> Yes <input type="checkbox"/> Return travel No <input type="checkbox"/> Yes <input type="checkbox"/>	

3.5 CERTIFICATION BY DOCTOR OR AUTHORISED REPRESENTATIVE

Authorised representatives can be a registrar, resident medical officer, intern, allied health professional, nursing unit manager or administrative staff such as a receptionist.

I certify that the information in this form is true and correct.

Signature	Date	Full name
	/ /	
		Position title of person signing Section 3.5

Privacy Note: 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.

IPTAAS CONTACT DETAILS

For more information about IPTAAS please contact your local IPTAAS office using the details below.

<p>Hunter New England – Tamworth Phone: 1800 478 227 + Select option 1 Fax: (02) 6766 4576 Email: hnelhd-iptaas@hnehealth.nsw.gov.au Post: IPTAAS Coordinator Locked Bag 9783, Tamworth NEMSC NSW 2348</p>	<p>Central Coast, Illawarra Shoalhaven, Murrumbidgee, Nepean Blue Mountains, Northern Sydney, Southern NSW, South Eastern Sydney, South Western Sydney, Sydney, Western NSW, Western Sydney Phone: 1800 478 227 + Select option 4 Fax: (02) 8797 6543 Email: iptaaas@health.nsw.gov.au Post: IPTAAS Coordinator Locked Bag 5270 Parramatta NSW 2124</p>
<p>Northern NSW, Mid North Coast – Port Macquarie Phone: 1800 478 227 + Select option 2 Fax: (02) 5524 2996 Email: tfh-iptaas@ncahs.health.nsw.gov.au Post: IPTAAS Coordinator PO Box 126, Port Macquarie NSW 2444</p>	<p>Over the counter services are available at Port Macquarie, Dubbo, Tamworth and Broken Hill.</p>
<p>Far West – Broken Hill Phone: 1800 478 227 + Select option 3 Fax: (08) 8080 1695 Email: fwlhd-iptaas@health.nsw.gov.au Post: IPTAAS Coordinator Broken Hill Health Service PO Box 457, Broken Hill NSW 2880</p>	<p>Alternatively, phone 1800 IPTAAS (1800 478 227) to speak to one of our friendly customer service staff for details of your nearest office.</p>

1800 IPTAAS (1800 478 227) 9am-5pm weekdays. ABN: 65 697 563 521
iptaaas@health.nsw.gov.au | www.iptaas.health.nsw.gov.au