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Australian Government
Department of Human Services

medicare

Medicare Claim

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 ☐☐☐☐ – ☐☐☐☐☐ – ☐

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?

Yes ☐ What is your reference number on the above Medicare card? ☐ ***Go to 7***

No ☐ Claimant's Medicare card number ☐☐☐☐ – ☐☐☐☐☐ – ☐ Ref no. ☐

3 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

4 Your date of birth / /

5 Your 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?

Yes ☐ ***Go to 8***

No/unsure ☐ *please provide address*

Postcode

Do you want this recorded as your permanent postal address for everyone on your Medicare card? Yes ☐ No ☐

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?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

11 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 the claimant provides their bank account details.

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

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

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.

Yes ☐

Please give details of your agent

Full name

Permanent address

Postcode

Agent's signature

No ☐

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 at **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 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, and
- the information in this form is complete and correct.

Claimant's signature

Date / /

Privacy and your personal information – 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 **The Department of Human Services**. 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, 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.

Australian Organ Donor Register *(optional)*

1 Your Medicare card number – – Ref no.

2 Your details

Family name

First given name

Permanent 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 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 / /

For more information

Go to **humanservices.gov.au/organdonor** or call the Australian Organ Donor Register on **1800 777 203**. **Note**: Call charges apply from mobile phones.

Privacy notice – Your personal information is protected by law, including the *Privacy Act 1988*, and is collected for a Social Security, Family Assistance, Medicare, Child Support and CRS purpose, depending on the service or payment concerned. This information may be required by law or collected voluntarily when you apply for services or payments. Your information is used for the assessment and administration of payments and services and may also be used within Human Services; or disclosed to other parties or agencies, where you have provided consent or it is required or authorised by law. You can get more information about privacy by going to our website at **humanservices.gov.au/privacy** or requesting a copy of the full privacy policy at any of our Service Centres.