Australian Government
Department of Human Services

medicare

Medicare Claim

Purpose of this form: Only use this form when claiming by mail or service centre drop box for paid and unpaid accounts.

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

Returning your form: Send the completed form and original accounts and receipts to: **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 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 expense(s). The Medicare benefit(s) 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 Gender 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 expense(s) on behalf of the patient
OR
executor/administrator name

7 Postal address – Do you want to use the address you have recorded with us?

No/unsure ☐ Provide address

Postcode

Yes ☐ ***Go to 9***

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

9 Email (optional)

@

10 Daytime phone number ( )

Service details

– The medical service(s) you are claiming benefit for.

11

Ref no.	Patient's first given name	Services provided by (e.g. Dr A P Jones)	Account paid in full?
			No ☐ Yes ☐
			No ☐ Yes ☐
			No ☐ Yes ☐

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

No ☐

Yes ☐ Date of admission / / Date of discharge / /

Bank account details – Important

Medicare benefits are only made through Electronic Funds Transfer (EFT)

13 Have you previously supplied your bank account details? No ☐ Yes ☐ ***Go to 15***

14 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.

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

15 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.

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 may apply.

Claimant's declaration

16 I hereby claim benefit(s) 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
- I am the executor or administrator acting on behalf of the deceased claimant's estate (if applicable)
- 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, a 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 where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

You can get more information about the way in which the department will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy**

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