Australian Government
Department of Human Services

Mental Health Nurse Incentive Program claim

Important information

The Mental Health Nurse Incentive Program (MHNIP) provides funding to eligible private psychiatry practices, general practices and other appropriate organisations to engage or retain credentialed mental health nurses.

Please refer to the corresponding *Mental Health Nurse Incentive Program Guidelines* (Program Guidelines) before completing the MHNIP claim form.

The Department of Human Services (Human Services) must be advised immediately of any relevant changes to the arrangements in place with the organisation, including business, banking and address details.

All correspondence will be sent to the authorised contact person at the postal address previously provided. The authorised contact person is responsible for notifying Human Services in writing, of any changes to organisation arrangements.

It is an offence under the *Human Services (Medicare) Act 1973* and the *Commonwealth Crimes Act 1914* to give false and misleading information.

Please advise us of your eligible organisation number and eligible organisation name.

Multiple session information logs can be submitted with each claim. This allows the organisation to claim sessions undertaken by multiple credentialed mental health nurses over a number of days.

A new session information log is required for each nurse, for each day.

A service outlet is the physical location of the office or clinic where the nurse is based for the day.

Please ensure all the details of the mental health nurse undertaking the session(s) are completed in full and the authorised contact person and the witness has read the declaration and understands the conditions before signing the form.

Assistance

For more information about the MHNIP email **mhnip@humanservices.gov.au** or go to **www.medicareaustralia.gov.au >For health professionals >Incentives and Allowances >Mental Health Nurse Incentive Program**. If you need assistance completing this form call the MHNIP on **1800 222 032** (call charges may apply) between 8.30 am and 5.00 pm, Monday to Friday, Australian Central Standard Time.

Claiming information

Payments will be made before the end of the month that immediately follows the month in which the claim form has been received by Human Services. For example, if a claim form is received by Human Services on 20 July 2011, the payment will be made to the organisation by 31 August 2011.

Organisations must complete a separate claim form for each nurse engaged (see page 2 of the form), and for each session undertaken by the nurse. All claim form details must be completed in full for Human Services to process the claim for payment.

Claim forms will be accepted up to 6 months after the date the session being claimed was undertaken. Claims received after 6 months following the corresponding session date will not be processed for payment.

Eligible organisations will not be able to claim for sessions that occurred before the program start date of 1 July 2007, or Human Services receipt of the organisation's completed application form to register for the MHNIP.

Lodgement details

Send the completed and signed form to:

Mental Health Nurse Incentive Program
GPO Box 2572
ADELAIDE SA 5001

or fax to: **1300 581 573**

Print in BLOCK LETTERS

Tick where applicable ☑

Session information log

1 Eligible organisation identification number

2 Eligible organisation name

Nurse information (a separate individual session information log per nurse is required ONE FORM, ONE NURSE)

3 Name of mental health nurse undertaking session

4 Mental health nurse date of birth / /

5 Mental health nurse engagement date / /

6 Is the nurse employed under a shared employment arrangement No ☐ Yes ☐

7 Credential number†

8 Credential expiry date / /

9 Session information

Start time ___ AM ☐ PM ☐ Session number ___ Date of session / / Locality/suburb of service outlet ___ Service outlet postcode ___

Patient Medicare or Department of Veterans' Affairs file number (include patient's individual reference number)	Patient full name	Patient under shared care plan?	Patient sex	Patient date of birth	Patient postcode (current residential postcode)	Face to face consult	Provider number of supervising medical practitioner	Name of supervising medical practitioner
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		

Start time ___ AM ☐ PM ☐ Session number ___ Date of session / / Locality/suburb of service outlet ___ Service outlet postcode ___

Patient Medicare or Department of Veterans' Affairs file number (include patient's individual reference number)	Patient full name	Patient under shared care plan?	Patient sex	Patient date of birth	Patient postcode (current residential postcode)	Face to face consult	Provider number of supervising medical practitioner	Name of supervising medical practitioner
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		
		Yes ☐	M ☐ F ☐	/ /		No ☐ Yes ☐		

† Credential number is ACMHN

Session details

10 Total number of sessions claimed

Total number of face to face consultations

Total number of Individual session information logs attached to this claim form

Organisation details

11 Eligible organisation identification number

12 Eligible organisation name

Declaration

13 **I understand that:**

- if the organisation cannot provide evidence of compliance with the Program Guidelines, the organisation's payments may be suspended, ceased or recovered and eligibility for the payment may be affected.

I declare that:

- the requirements for eligibility set out in Section 9 of the Program Guidelines and acknowledge that the Department of Human Services may require evidence that the organisation satisfies these requirements.
- the organisation will inform the Department of Human Services in writing within 10 working days, at the address shown on this claim form, if there is any change in arrangements that will affect eligibility for this payment.
- the information provided in this form is true and correct and the organisation will be able to provide evidence in support of the statement.

Name of authorised contact person

Authorised contact person's signature

✍

Date

/ /

Privacy note

The information provided in this form will be used to assess and calculate Mental Health Nurse Incentive Program payments. The collection of this information is authorised by the *Human Services (Medicare) Act 1973*. With the exception of the Department of Human Services or Department Veterans' Affairs file number provided, information collected on this form may be disclosed to the Department of Health and Ageing for the purposes of administering this program or as authorised or required by law.

Checklist

Have the eligible organisation details been completed? (refer to questions 1-2)	☐
Has the declaration been completed (including the date) and signed by the authorised contact person? (refer to question 13)	☐
Are the mental health nurse details correct? (refer to question 3-8)	☐
Have the individual patient(s) details been recorded in the session information section? (refer to question 9)	☐
Has all provider information been recorded? (refer to question 9)	☐

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