Australian Government
Medicare Australia

# Residential Medication Management Reviews (RMMR)
# Multiple-lodgement claim

(Please complete one claim form for each accredited pharmacist providing RMMR services)

PBS

**OFFICE USE ONLY**

Claim identification (ID) number

**Important information**

Complete in **BLOCK LETTERS** and use **black pen** only.
If you require assistance in completing this form call Medicare Australia on **08 8274 9641** (call charges apply) or visit **www.medicareaustralia.gov.au**

**Lodgement**
Send completed and signed form to:
**Community Pharmacy Agreement Officer**
**Pharmaceutical Benefits Branch**
**Medicare Australia**
**PO Box 9826**
**Adelaide SA 5001**

1 Pharmacy approval number or program ID number

2 Name of approved RMMR service provider

3 Aged Care service ID

4 Name of aged care home

5 Accreditation certificate number

6 Name of accredited pharmacist

7 Claimant's reference number

8 Contact number for claiming ( )

| | **Medicare or DVA file number** (include all 11 numbers if using Medicare number) | **Patient's first given name** | **Patient's family name** | **Patient's date of birth** | **RMMR review date** | **Type of service ✓ whichever** | | **Complete where collaborative** | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Pharmacist | Collaborative | Referral obtained Yes No | Provider number of requesting general practitioner (GP) | Name of requesting GP |
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**Certification**

**I certify that:**

- the details on this form are true and correct and that the **RMMR** services being claimed were conducted in accordance with the program application and terms and conditions
- Quality Use of Medicine (**QUM**) activities have been undertaken and details are included in the QUM quarterly report.

Family name ____ Given name ____ Signature of approved RMMR service provider ____ Date / /

Family name ____ Given name ____ Signature of director of nursing or authorised representative ____ Date / /

Family name ____ Given name ____ Signature of accredited pharmacist ____ Date / /

(must sign twice if accredited pharmacist is the same as approved service provider)

**Privacy note**: The information collected on this form will be used to assess your claim for Residential Medication Management Reviews and associated Quality Use of Medicines services. Its collection is authorised by the *National Health Act 1953* and it may be disclosed to the Department of Health and Ageing, or as authorised or required by law.

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