



# Applying for approval to supply pharmaceutical benefits at a particular premises

## Important information

Complete this form if you are applying for approval to supply pharmaceutical benefits at a particular premises in any of the following circumstances:

- expanding or contracting approved pharmacy premises, or
- relocating an approved pharmacy, or
- relocating an approved pharmacy (with a change of ownership), or
- establishing a new pharmacy.

For change of ownership of a pharmacy only applications, please use *Application for approval - Change of ownership of a pharmacy (not involving relocation)* available at [www.humanservices.gov.au](http://www.humanservices.gov.au) click on Medicare.

Applicants should refer to the 'Pharmacy Location Rules - Applicant's Handbook' before completing this form. The Handbook provides information about The Rules and what types of documentation must be attached when submitting this form.

You should ensure that you have a current copy of the Applicant's Handbook. If you do not have a copy of the Handbook:

- go to [www.health.gov.au/ACPA](http://www.health.gov.au/ACPA) or
- call the Australian Community Pharmacy Authority (ACPA) secretariat on **02 6289 2419**.

## Access to PBS benefits - online claiming

If you wish to apply for Online Claiming for PBS, complete part two of this form and send it together with this application to the address listed under lodgement.

## Assistance

For more information go to [www.humanservices.gov.au](http://www.humanservices.gov.au) or for assistance completing this form call **132 290** (call charges may apply) between 8.30 am and 5.00 pm, Monday to Friday, local time, and ask for the Pharmacy Program Officer in your state or territory.

## Lodgement

It is the applicant(s) responsibility to ensure that the application is complete as declared in question 24 of this form, before it is sent to the Department of Human Services. The date an application is taken to have been made, is the date it is complete and registered by the Department of Human Services.

The completed application must be posted to:

**Pharmacy Program Officer**  
**Department of Human Services**  
**GPO Box 9826**  
in your capital city

Please retain a copy of your application for your records.

Print in **BLOCK LETTERS**

Tick where applicable

## Pharmacy Location Rule

**1** You must indicate the Pharmacy Location Rule under which you are applying

### Expanding or contracting approved pharmacy premises

Rule 121 Expansion or contraction

In accordance with section 90 (3AE) of the *National Health Act 1953* most applications under this rule are not referred to the ACPA.

or

### Relocating an approved pharmacy

Rule 122 (within a facility)

Rule 123 (within the same town - 10km)

Rule 124 (short distance - 1km)

Rule 125 (short distance between 1-1.5 km)

Rule 126 (long distance)

Rule 127 (population growth)

Rules 125, 126 and 127 apply only where a legal right to occupy the proposed premises named in question 13 is established before 18 October 2011 and the application is registered on or before 16 April 2012.

### Relocations only

On the date an application is made, one or more approvals in respect of the existing approved premises described in question 17 must have been in force for at least two years. If not, please tick The Rule under which an exemption is being claimed:

relocating within the same facility, or

relocating within the same town, or

existing premises being renovated or refurbished, or

returning to renovated or refurbished premises, or

exceptional circumstances (e.g. existing premises damaged by fire or flood)

or

### Establishing a new pharmacy

Rule 130 (at least 1.5km)

Rule 131 (at least 10km)

Rule 132 (additional pharmacy at least 10km)

Rule 133 (small shopping centre)

Rule 134 (large shopping centre)

Rule 135 (private hospital)

Rule 136 (large medical centre)

## Applicant(s) details

**2** An applicant includes an individual, or company, friendly society, body corporate, trust or the like. Registration number is the number issued by the Pharmacy Board of Australia.

The full name (given names and family name) of each individual or the full company name, friendly society name or the like, is to be provided.

### Applicant one

Mr  Mrs  Miss  Ms  Other

Family name

First given name

Registration Number (individual applicant only)

### Applicant two

Mr  Mrs  Miss  Ms  Other

Family name

First given name

Registration Number (individual applicant only)

### Applicant three

Mr  Mrs  Miss  Ms  Other

Family name

First given name

Registration Number (individual applicant only)

### Applicant four

Mr  Mrs  Miss  Ms  Other

Family name

First given name

Registration Number (individual applicant only)

## Applicant five

Mr  Mrs  Miss  Ms  Other

Family name

First given name

Registration Number (individual applicant only)

## Applicant six

Mr  Mrs  Miss  Ms  Other

Family name

First given name

Registration Number (individual applicant only)

**3** Is/are the applicant(s) named in question 2 a company, friendly society, body corporate, a trust or the like?

No  **Go to 4**

Yes

1. Name of company or friendly society etc.	
Full name (given names and family name) of person(s) authorised to act on behalf of the above.	Registration Number

I/we have attached evidence (e.g. ASIC report) confirming my/our authority to act on behalf of the above.

2. Name of company or friendly society etc.	
Full name (given names and family name) of person(s) authorised to act on behalf of the above.	Registration Number

I/we have attached evidence (e.g. ASIC report) confirming my/our authority to act on behalf of the above.

There are more than two companies, friendly societies, etc. being represented and a separate sheet with the details, as above, is attached.

## Applicant(s) contact details

You must provide the contact details of the applicant or one of the applicants named in question 2 who is authorised to discuss this application.

4 Mr  Mrs  Miss  Ms  Other

Family name

First given name

5 Postal address

Town/Suburb

Postcode

6 Daytime phone number

Mobile phone number

Fax number

Email

## Authorised representative

7 Has a person, other than the applicant(s), been authorised to act on behalf of one or more of the applicants named in question 2?

No  **Go to 12**

Yes

8 Full name of representative (given names and family name)

Mr  Mrs  Miss  Ms  Other

Family name

First given name

9 Company name

Applicant(s) represented in question 2: e.g. Applicant one, two or three etc

10 Postal address

Town/Suburb

Postcode

11 Daytime phone number

Mobile phone number

Fax number

Email

Representative's signature

## Proposed premises

This section must be completed for all applications

12 Pharmacy trading name

13 Address of proposed pharmacy premises

Town/Suburb

Postcode

14 I/we request approval to supply pharmaceutical benefits at the proposed premises with effect from:

 / / (anticipated opening date)

### Next steps

If this application is being made under:

Rule 121 (expansion or contraction) or Rules 122 to 127 (relocations) go to question 15

Rules 130 to 136 (new pharmacy), go to question 24

**Questions 18 to 23 are to be completed by the current owner(s) of the existing approved premises** (complete for expansion or contraction or relocation of an existing pharmacy)

## Existing approved premises

15 PBS Approval number

16 Pharmacy trading name

17 Address of pharmacy premises

Town/Suburb

Postcode

## Current owners

- 18** All current approved pharmacist(s) or persons acting on behalf of a company, friendly society, body corporate, trust or the like must be named.

### Owner one

Mr  Mrs  Miss  Ms  Other

Family name

First given name

### Owner two

Mr  Mrs  Miss  Ms  Other

Family name

First given name

### Owner three

Mr  Mrs  Miss  Ms  Other

Family name

First given name

### Owner four

Mr  Mrs  Miss  Ms  Other

Family name

First given name

### Owner five

Mr  Mrs  Miss  Ms  Other

Family name

First given name

### Owner six

Mr  Mrs  Miss  Ms  Other

Family name

First given name

## Current owner(s) contact details

- 19** Name of a current owner that we can discuss this application with.

Family name

First given name

- 20** Postal address

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-----

Town/Suburb  Postcode

- 21** Daytime phone number

Mobile phone number

Fax number

(  )

Email

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@

- 22** An approval has been in force at the premises described in question 17 for a period of two or more years, or
- An approval has been in force at the premises described in question 17 for a period of less than two years.

## Current owner(s) declaration and request

- 23** I/we request that:

- My/our approval under Section 90 of the *National Health Act 1953* (the Act) to supply pharmaceutical benefits at the premises described in question 17 be cancelled under Section 98 of the Act with effect immediately prior to granting an approval to the applicant(s) in respect of premises described in question 13.


Current owner one signature



Date

/  /

Current owner two signature



Date

/  /

Current owner three signature



Date

/  /

Current owner four signature



Date

/ /

Current owner five signature



Date

/ /

Current owner six signature



Date

/ /

### Applicant(s) declaration

#### 24 I/we understand that:

- giving false or misleading information is a serious offence
- an application made under Section 90 of the *National Health Act 1953* for approval to supply pharmaceutical benefits at a particular premises (the proposed premises), comprises this form and all documentation as specified in the 'Pharmacy Location Rules - Applicant's Handbook' for The Rule nominated in question 1
- the date the application is taken to have been made, is the date it is complete and registered by the Department of Human Services
- documentation related to this application which I/we send to the Department of Human Services or the Australian Community Pharmacy Authority (ACPA) after the date the application is registered, will not be considered by the ACPA.

#### I/we declare that:

- I/we and/or my/our authorised representative nominated in question 8 have read the 'Pharmacy Location Rules - Applicant's Handbook', and
- the documentation needed to satisfy the requirements of The Rule nominated in question 1, is attached and
- the information on this form is correct and
- the application is complete.

Applicant one signature



Date

/ /

Applicant two signature



Date

/ /

Applicant three signature



Date

/ /

Applicant four signature



Date

/ /


Applicant five signature



Date

/ /

Applicant six signature



Date

/ /

### Privacy note

The information collected on this form will be used to assess your eligibility to supply pharmaceutical benefits at the proposed premises. The collection of this information is authorised by the *National Health Act 1953*. This information may be disclosed to the Australian Community Pharmacy Authority, the Department of Health and Ageing, or as authorised or required by law.

Do you wish to lodge your **PBS claims online**?  
If so, please turn over

### Office use only

Date received:

/ /

If this form is complete and the applicant(s) has/have declared the application complete at question 24

Date registered:

/ /

Application number allocated:

.....

PPO Initials:

If this form is not complete, why?

.....  
.....



## Terms and conditions

In clause 1 of these terms and conditions, a reference to 'I', 'me' or 'my' is to be construed as a reference to the parties agreeing to these terms and conditions and to any parties acting on their behalf.

### 1. I agree:

- a) to comply with these terms and conditions for Online Claiming for PBS
- b) that Medicare Australia may change or add to these terms at any time, by giving me notice by mail, fax or electronically. A message sent to my business email address (as held in Medicare Australia records) or by notice published on Medicare Australia's website at **www.medicareaustralia.gov.au** is one way of giving me notice electronically
- c) that if I use Online Claiming for PBS after I have been notified of a change or addition to these terms, I will be taken to have agreed to that change or addition in respect of all uses of Online Claiming for PBS after that date. These terms may not be changed orally or by conduct
- d) to use a version of a software product approved by Medicare Australia when conducting a transaction with Medicare Australia using Online Claiming for PBS. I understand that Medicare Australia may revoke its approval of a version of a software product at any time
- e) that by approving a particular version of a software product, Medicare Australia is not representing that the product is suitable for any purpose or that the product meets any quality standards
- f) that Medicare Australia may from time to time change its technical requirements in relation to the use of Online Claiming for PBS, which may require me to upgrade my software
- g) that Medicare Australia is not responsible for any costs, losses or damage I incur in connection with the Online Claiming for PBS systems (including, without limitation, communication costs, support costs, software acquisition or losses associated with the Online Claiming for PBS system being from time to time inoperative or inaccessible)
- h) to ensure all communications I send to Medicare Australia using Online Claiming for PBS are signed and secured using PKI software approved by Medicare Australia at the time of the communications and my Site Certificate, valid at the time of the communication
- i) to ensure my Site Certificate is loaded into my software in accordance with instructions and stored in a secure place once loaded
- j) that I must comply with the *National Health Act 1953* and other legislation including, but not limited to, Acts, Rules and Regulations
- k) that if I use Online Claiming for PBS to adjust or correct information in respect of a claim previously lodged with Medicare Australia, Medicare Australia may make an amendment to the amount which may become payable to me
- l) that Medicare Australia may at any time, at its absolute discretion, restrict, suspend or terminate my access to Online Claiming for PBS with Medicare Australia, whether because of a breach of these terms and conditions or for any other reason

- m) that I may terminate this agreement with Medicare Australia by giving written notice to Medicare Australia. I understand that I will not be able to conduct transactions with Medicare Australia using Online Claiming for PBS after I give such notice
  - n) that if this agreement is terminated, my obligations under these terms and conditions will continue in respect of any claims I made using Online Claiming for PBS before the date of termination.
2. I, and any person acting on my behalf, agree that any use of Online Claiming for PBS is deemed to be an authorised use.
  3. These terms and conditions are issued under and are to be construed in accordance with the laws in force from time to time in the Australian Capital Territory. All parties submit to the exclusive jurisdiction of the courts of the Australian Capital Territory and courts of appeal from them. Neither party will object to the exercise of jurisdiction by those courts on any basis.

## Declaration

### 10 I/we declare that:

- I/we have read and agreed to the terms and conditions
- I am authorised to sign this declaration on behalf of all other applicants
- the information on this form is correct

Name

Position

Daytime phone number

Email address

  
-----  
@

Signature

Date

## Privacy Note

The information provided on this form will be used to assess eligibility to use Online Claiming for PBS. The collection of this information is authorised by the *National Health Act 1953*. This information may be disclosed to the Department of Health and Ageing, other relevant government agencies or as authorised or required by law.