



## Certification of cleft condition prescribed dental patient

### Important information

Complete this form if you are a recognised medical practitioner and/or dental practitioner for prescribed dental patients to receive Medicare benefits under the Cleft Lip and Cleft Palate Scheme.

If the person is over 22 years of age and has never been registered as a prescribed dental patient, they **will not** be eligible for registration or benefits under the scheme.

If the person is 28 years old and was registered in the scheme before they turned 22 and they require a specific course of treatment for repair of previous reconstructive surgery, they **could** be eligible to claim benefits.

Medicare benefits can be claimed for cleft lip and cleft palate conditions until the age of 28 years. The cleft lip and cleft palate identification card has an expiry date of the day before the person with the cleft condition turns 28 years.

### Assistance

If you need assistance completing this form call **1300 652 492** or **132 150** (call charges may apply). For more information about the Cleft Lip and Cleft Palate Scheme go to [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) > **For individuals and families > Medicare > Schemes and initiatives > Cleft Lip and Cleft Palate Scheme**

### Lodgement

Complete, sign and make two copies of the original. A copy is to be retained by the patient, the clinic and/or practitioner and the original to be sent to:

**Cleft Lip and Cleft Palate Scheme**  
**PO Box 9822**  
**Perth WA 6848**

or fax to: **08 9214 8129**

or place in the 'drop box' at your local Medicare office.

Print in **BLOCK LETTERS**

Tick where applicable

### Provider's details

**1** Medicare Provider number

**2** Dr  Mr  Mrs  Miss  Ms  Other

Family name

First given name

**3** Practice name

**4** Practice address

  


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Postcode

**5** Phone number

Mobile phone number

### Patient's details

To be completed by the provider.

**6** Medicare card number

 -  -  Ref no. 

**7** Mr  Mrs  Miss  Ms  Other

Family name

First given name

**8** Address

  


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Postcode

**9** Date of birth

 /  / 

**10** Phone number

**11** Patient's condition

- cleft lip   
 cleft palate   
 cleft lip and cleft palate   
 specified condition  Provide details below

  


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## Certification of patient's date of birth

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To be completed by a parent/guardian (or patient, if 18 years or over) for the certification of the patient's date of birth.

### 12 I certify that:

Patient's full name

Date of birth

Parent or guardian's full name (if applicable)

Relationship to patient (if applicable)

Patient or parent/guardian's signature

Date

## Declaration

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### 13 I declare that:

- I am an approved medical practitioner and/or dental practitioner as referred to in the definition of 'prescribed dental patient' in Section 3BA of the *Health Insurance Act 1973*
- the information on this form is correct.

Approved medical practitioner or dental practitioner's signature

Date

## Privacy note

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The information on this form will enable prescribed dental patients to receive Medicare benefits under the Cleft Lip and Cleft Palate Scheme. The collection of this information is authorised by the *Health Insurance Act 1973*. This information may be disclosed to the Department of Health and Ageing, Department of Veterans' Affairs, private health funds and other approved organisations or as authorised or required by law.