Australian Government
Medicare Australia

Balimed claim

Complete this form to claim Bali Special Health Care benefits

(Please tick relevant box/boxes) ☐ Hospital ☐ Pharmaceutical ☐ Allied ☐ Medical

Section 1. Applicant's details

1. Patient's Medicare card number
2. Name of the person who received the goods and/or services
   Title eg. Mr/Mrs | Family name | First name

   (Payments will be addressed to this person)
3. What is your current mailing address? | Daytime telephone number ( )
   Postcode
4.

For goods & services provided by e.g. Dr AP Jones/ABC Pharmacy	Has this account been paid 'Yes' or 'No'

5. Are you a member of a private health fund? Yes ☐ No ☐
6. If yes, name of your private health fund
7. Membership number
8. Type of cover — Hospital ☐ Allied ☐
9. Have you claimed from your fund? Yes ☐ No ☐
10. Are any expenses recoverable through any other type of insurance? Yes ☐ No ☐
11. If yes, name of company where policy is held

Section 2. Electronic funds transfer (EFT) details

Complete this section to have a benefit paid into your nominated financial institution.

1. Name the account is held in:
2. BSB number *(6 digits in total)* — Financial institution account number *(up to 9 digits only)*

   (If you are unsure of the BSB number, please contact the financial institution where the account is held.)
3. Financial institution:

   Branch location:

Section 3. Claimant declaration

I hereby claim payment for out-of-pocket expenses incurred as a result of the Bali bombing of 12 October 2002 and I declare that:

- I am eligible to receive assistance under the Bali special health care benefits scheme
- the goods and/or services are as a result of the Bali bombing of 12 October 2002
- that all other entitlements and benefits (both government and insurance) have been claimed where possible
- all of out-of-pocket expenses claimed by me relate to goods/and or services for which I am entitled to claim payment under the Bali special health care benefits scheme
- to the best of my knowledge and belief all the information in this claim is true and correct.

I also authorise Medicare Australia to contact the provider of the goods and/or services and/or the originator of any documentation if clarification of details on accounts/receipts/statements is required for payment purposes.

Signature of claimant* ✍ Date: / /

* The person who received the goods and/or services.
All documents supporting this claim will be retained by Medicare Australia

Section 4. Submitting your claim

Please submit your completed claim form together with any accounts, receipts, Medicare or private health insurance documentation to one of the following:

- **Medicare Australia Special Assistance, Reply Paid 9822, Perth WA 6848** (no stamp required)
- at your local Medicare office
- fax to **08 9214 8129**.

Section 5. Claim enquiries

For enquiries call the Medicare Australia Special Assistance enquiry line on **1800 660 026****
(Monday to Friday between 7.30 am and 5.00 pm Australian Western Standard Time).

Section 6. Privacy note

I consent to Medicare Australia using my Medicare card number to validate appropriate payments. I also consent to Medicare Australia checking Medicare Benefits Schedule payments, Pharmaceutical Benefits Schedule payments and private hospital payments or undertaking verification related to any other benefit program or assistance provided by the Australian state/territory Government or by any other non-government organisation to which this scheme may be directly related. I consent to and authorise Medicare Australia obtaining personal information from other agencies and organisations on the understanding that the information will be handled sensitively and appropriately for the purpose of assessing registration and claims. Information obtained from this form may be disclosed to the Department of Health and Ageing, the Department of Human Services, The Department of Family and Community Services, Centrelink, other relevant Australian Government and state/territory government agencies and other organisations providing relevant assistance for monitoring and assessment purposes (for example charities or overseas organisation) and/or to enable those bodies to offer assistance. I understand that benefits are provided under the scheme as a result of information that I have provided and that providing false or misleading information may result in Medicare Australia recovering benefits.

Office use only

Payment amount to claimant | Payment amount to provider or pharmacist

Approved by (Please print name) | Signature ✍

**** Call charges apply from mobile or pay phones only**

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