



Tsunami 2004 Health Care Assistance claim

Complete this form to claim Tsunami 2004 Health Care Assistance
(Please tick relevant box/boxes) Hospital Pharmaceutical Ancillary Medical

Section 1 Patient details—This section must be completed

1. What is your Medicare card number?

2.

Patient first name	Provider of goods or services eg. Dr AP Jones/ABC Pharmacy	Account paid 'Yes' or 'No'

If the accounts have been paid in full and you require electronic funds transfer payment, please also complete Section 4. If the accounts are unpaid, a cheque will be made out to the provider and posted to the person named in Section 3.

Section 2 Private health fund details

1. Are you a member of a private health fund? Yes No
2. If yes, name of your private health fund
3. Membership number
4. Type of cover Hospital Ancillary Both
For benefits to be paid, please ensure you claim from your private health fund or other insurance fund prior to making this claim.
5. Have you claimed from your fund? Yes No
6. Are any expenses recoverable through any other type of insurance? Yes No

Section 2 Private health fund details

1. What is the name of the person who paid or is liable to pay for these medical expenses?
Title eg. Mr/Mrs Family name First name
(Payments will be addressed to this person)
2. What is the claimant's current mailing address?

 Postcode
3. What is your daytime telephone number? ()

Section 4 Electronic funds transfer (EFT) details

- Complete this section to have your benefit paid into a 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)
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(If you are unsure of the BSB number, please contact the financial institution where the account is held.)
3. Financial institution Branch location

Section 5 Claimant declaration

I hereby claim payment for out-of-pocket expenses incurred as a result of a tsunami on 26 December 2004 and I declare that:

- I am eligible to receive assistance under the Tsunami 2004 Healthcare Assistance Scheme
- the goods and/or services are as a result of a tsunami on 26 December 2004
- that all other entitlements and benefits (both government and insurance) have been claimed where possible
- all out-of-pocket expenses claimed by me relate to goods and/or services for which I am entitled to claim payment under the Tsunami 2004 Healthcare Assistance 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 is liable to pay for the goods and/or services.
All documents supporting this claim will be retained by Medicare Australia.

Section 6 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 7 Claim enquiries

Any enquiries regarding claims may be made by calling 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 8 Privacy note

The information provided on this form will be used to assess your eligibility and assist in the payment of claims. Medicare Australia may need to contact your medical practitioner, pharmacist or other health care worker for clarification of your claim. Some information obtained from this form may be released to the Department of Health and Ageing, Department of Human Services, Centrelink, other relevant agencies and organisations for monitoring and assessment purposes.

Office use only

Payment amount to claimant \$

Payment amount to provider or pharmacist \$

Approved by (Please print name)

Signature Date: / /

**Call charges apply from mobile and pay phone only.