



If you are unsure about how to complete this form or whether you are eligible, please 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)

(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

5. Have you claimed from your fund—for benefits to be paid, please ensure you claim from your private health fund or other insurance fund prior to making this claim.
Yes No

6. Are any expenses recoverable through any other type of insurance?
Yes No

Section 3 Claimant details—This section must be completed

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 the bombings in London on 7 July 2005, and I declare that:

- I am eligible to receive assistance under the London Assist Scheme
- the goods and/or services are required for healthcare arising as a result of the London bombings of 7 July 2005
- 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 London Assist 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 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

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 Date:

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