Instructions Print Clear

Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)

IPTAAS Registration number

Claim Form

If this claim is the first visit to your specialist, please also complete an IPTAAS Doctor Referral form.

PART 1 – PATIENT AND ESCORT DETAILS

1.1 ELIGIBILITY DETAILS

Have you claimed, or are you entitled to claim, travel and/or accommodation benefits from any of the following:

1. Any Australian, State or Territory government scheme other than IPTAAS?	No ☐ Yes ☐	*If 'Yes', please contact your nearest IPTAAS Office to confirm ineligibility*
2. As part of a Workers Compensation claim?	No ☐ Yes ☐	
3. As part of any insurance claim?	No ☐ Yes ☐	
4. Do you have a Veterans' Affairs (DVA) Gold Card?	No ☐ Yes ☐	

1.2 PATIENT DETAILS

Title | Surname | Given name | Date of birth (/ /)

Residential address

Postcode

Postal address

Postcode

Daytime phone number | Mobile number | Email address

Preferred contact method

Email ☐ Mail ☐ Daytime phone ☐ Mobile phone ☐

Medicare card details

Card number | Position on card

Are you Aboriginal/Torres Strait Islander? No ☐ Yes ☐

Alternate contact person details

Name | Phone number

1.3 ESCORT DETAILS *(if applicable)*

An escort is a person who, for medical reasons, is required to accompany an IPTAAS patient while travelling to specialist medical treatment

Title | Surname | Given name

1.4 CONCESSION DETAILS AND CENTRELINK CONSENT

Do you or your escort have a Pension or Health Care Card?

No ☐ ▶ *Go to **Section 1.5** on page 2*

Yes ☐ ▶ *Give details below*

I/We authorise:

- EnableNSW to use Centrelink Confirmation eServices to perform a Centrelink/DVA enquiry of my Centrelink or Department of Veterans' Affairs Customer details and concession card status in order to enable the business to determine if I qualify for a concession, rebate or service.
- The Australian Government Department of Human Services (DHS) to provide the results of that enquiry to EnableNSW.

I understand that:

- DHS will use information I have provided to EnableNSW to confirm my eligibility for EnableNSW programs and services and will disclose to EnableNSW personal information including my name, address, payment and concession card type and status.
- This consent, once signed, remains valid while I am a customer of EnableNSW unless I withdraw it by contacting EnableNSW or DHS.
- I can obtain proof of my circumstances/details from DHS and provide it to EnableNSW so that my eligibility for EnableNSW programs and services can be determined.
- If I withdraw my consent or do not alternatively provide proof of my circumstances/details, I may not be eligible for programs and services provided by EnableNSW.

Details about the Centrelink Confirmation eServices are available on Centrelink's website.

If you do not wish to authorise EnableNSW to confirm the current status of your Commonwealth Benefit and other details as they pertain to your concessional entitlement, **please attach a photocopy of your pension card**.

Note: A personal contribution of $30.00 will be deducted from this claim if you are **not** a Pension or Health Care Card holder.

Continued over page ▶

Patient name		Date of birth	/ /

1.4 CONCESSION DETAILS AND CENTRELINK CONSENT *continued*

Patient

Centrelink benefit number

Expiry date / /

Type of benefit

Patient's Signature

✗ If sending by post, a signature is required. A signature is not required if the form is sent by email and the email signature includes patient/carer details.

Date / /

Escort

Centrelink benefit number

Expiry date / /

Type of benefit

Escort's Signature

✗ If sending by post, a signature is required. A signature is not required if the form is sent by email and the email signature includes patient/carer details.

Date / /

1.5 BANK ACCOUNT DETAILS FOR CLAIM PAYMENT

Give details of the bank account you want your IPTAAS payments made to. Reimbursements will be made by Electronic Funds Transfer (EFT). If the details provided are incorrect, your payment will be delayed.

Account name

Name of bank, building society or credit union

BSB number

Account number

Email address for payment notice *(if different to that provided in 1.2)*

Should any part of this reimbursement be paid to another organisation or charity?

No ☐ Yes ☐

1.6 THIRD PARTY PAYMENT DETAILS – *Required if payment is to be made to a separate organisation*

Organisation name

Vendor number *(if known)*

Phone number

Which portion of the claim would you like paid to another organisation?

Travel ☐ Accommodation ☐ ▶ Specify amount to be paid $

1.7 BULK BILL ACCOMMODATION DETAILS *(if applicable)*

Name of accommodation provider

Contact person

Phone number

Fax number

Email address

TERMS AND CONDITIONS

- The patient must meet the eligibility criteria for IPTAAS.
- It is the responsibility of the accommodation provider to organise payment directly with the patient for any additional costs incurred outside of the IPTAAS guidelines
- Before the patient leaves the accommodation facility, Parts 2 and 3 of the IPTAAS Claim form is required, along with an accommodation invoice and any other claimable receipts.
- Invoices must include the conditional approval number, along with both the patient & escort name. Failure to do this may lead to non-payment of your invoice
- Any additional fees (e.g. late check-out) are subject to approval by IPTAAS.

Note: A personal contribution of $30 will be deducted from the total benefits payable for each return journey or weekly subsidy if claiming under the 200km per week cumulative distance criterion (not applicable to pensioners and Health Care Card holders). Contributions will be capped at four co payments each financial year. In cases where a personal contribution cannot be deducted from the claimant's travel entitlement the contribution is deducted from the accommodation entitlement and payment arrangements must be made between the service provider and the patient. No benefit is payable when the patient is on leave during the course of their treatment.

AUTHORISATION

Patient/Guardian

I have read and understood the terms of this bulk billing conditional approval and agree to meet all accommodation costs if I do not comply with the above conditions.

Signature of Patient/Guardian

✗ If sending by post, a signature is required. A signature is not required if the form is sent by email and the email signature includes patient/carer details.

Date / /

Accommodation Provider

I have read and understood the terms of this bulk billing conditional approval. I understand that it is the responsibility of the accommodation provider to seek payment of the accommodation costs from the claimant and therefore should assist the patient/claimant to complete the bulk billing application form where possible.

Signature of Accommodation Provider

✗ If sending by post, a signature is required. A signature is not required if the form is sent by email and the email signature includes patient/carer details.

Date / /

Patient name		Date of birth	/ /

PART 2 – TRAVEL AND ACCOMMODATION DETAILS

2.1 TRAVEL DETAILS

Use the following codes to help give details of your travel below

People travelling	Trip type	Transport type
P = Patient **E** = Escort **P/E** = Patient and Escort	**O** = One way **R** = Return	**A** = Ambulance **B** = Bus/Coach **F** = Ferry **R** = Rail **UA** = Unapproved Air **AA** = Approved Air **CT**=Community Transport **P** = Private car **T** = Taxi

Journey dates		Where was treatment received? *Specify address where treatment was received*	People travelling	Trip type	Transport type	Treatment date(s)		Specialist signature *If not confirmed electronically*
Start	/ /					Start	/ /	If sending by post, a signature is required. A signature is not required if the form is sent by email and the email signature includes patient/carer details.
End	/ /					End	/ /	
Start	/ /					Start	/ /	If sending by post, a signature is required. A signature is not required if the form is sent by email and the email signature includes patient/carer details.
End	/ /					End	/ /	

Copies of receipts and/or tax invoices for travel must be lodged with this claim. Scanned copies or clear photos of receipts can be emailed to IPTAAS with your claim forms.

Air approval number

Subsequent visits to the same specialist can be claimed by submitting an IPTAAS Travel Diary form signed by the specialist or authorised representative, together with copies of all receipts for travel by public transportation or accommodation.

2.2 ACCOMMODATION DETAILS

Give details of your accommodation – *See the IPTAAS Information Sheets if you require more information about accommodation types*

Was patient hospitalised?	Hospital admission date	Hospital discharge date	Accommodation type	Accommodation dates	
				Start date	End date
No ☐ Yes ☐	/ /	/ /	Private ☐ For profit ☐ Not for profit ☐	/ /	/ /
No ☐ Yes ☐	/ /	/ /	Private ☐ For profit ☐ Not for profit ☐	/ /	/ /
No ☐ Yes ☐	/ /	/ /	Private ☐ For profit ☐ Not for profit ☐	/ /	/ /
No ☐ Yes ☐	/ /	/ /	Private ☐ For profit ☐ Not for profit ☐	/ /	/ /

Copies of receipts and/or tax invoices for accommodation must be lodged with this claim. Scanned copies or clear photos of receipts can be emailed to IPTAAS with your claim forms.

Name of accommodation facility

Address of facility

Postcode

2.3 DECLARATION

I certify the information in this form is correct, the expenditure shown in Part 2 was actually incurred and benefits relating to that expenditure have not been received nor are claimable from another source, including private health funds. I hereby consent to NSW Health obtaining further information from referring medical practitioners, treating specialists, other health care professionals and travel/accommodation providers where it is required to process this application.

I understand that personal contribution of $30 will be deducted from the total benefits payable for each return journey or weekly subsidy if claiming under the 200km per week cumulative distance criterion (not applicable to pensioners and Health Care Card holders). Contributions will be capped at four co payments each financial year.

Privacy Note: The information contained in this application is protected by law from unauthorised access and misuse. The information will only be accessed by health service staff directly involved in providing services to the applicant, or with other lawful excuse.

Signature

✘ If sending by post, a signature is required. A signature is not required if the form is sent by email and the email signature includes patient/carer details.

Date / /

Patient name		Date of birth	/ /

PART 3 – SPECIALIST AND TREATMENT DETAILS

3.1 SPECIALIST DETAILS

Surname | Given name | Contact phone number

Address of treatment/consultation

Postcode

Email address | Specialist provider number | MBS number/service

3.2 TREATMENT / CONSULTATION DETAILS

Treatment/Consultation dates: From / / To / /

What type of treatment is the referral for?

Was hospitalisation necessary?

No ☐ Yes ☐ *Give details below*

Hospital address

Postcode

In hospital from / / | In hospital to / /

Is it medically necessary for the patient to remain near the location outside these dates?

No ☐ Yes ☐ How many nights?

3.3 ELIGIBILITY FOR AN ESCORT

An escort is a person who, for medical reasons, is required to accompany an IPTAAS patient while travelling to specialist medical treatment Patients under the age of 17 years are automatically entitled to one escort/carer

Does the patient require an escort/carer?

During travel	No ☐ Yes ☐	*If 'Yes', give details below of the medical reason(s) why an escort/carer is required to travel and/or remain with the patient during specialist treatment*
During treatment	No ☐ Yes ☐	

Specify the medical reason(s) why an escort/carer is required to travel and/or remain with the patient during specialist treatment

3.4 AIR TRAVEL DETAILS (if required)

If air travel is necessary for medical reasons, the medical practitioner must obtain approval by calling the local IPTAAS office before each journey.

Does the medical condition of the patient warrant air travel?

Forward travel No ☐ Yes ☐ | Return travel No ☐ Yes ☐

Prior approval number

3.5 CERTIFICATION BY DOCTOR OR AUTHORISED REPRESENTATIVE

Authorised representatives can be a registrar, resident medical officer, intern, nursing unit manager or administrative staff such as a receptionist.

I certify that the information in this form is true and correct.

Signature

✘ If sending by post, a signature is required. A signature is not required if the form is sent by email and the email signature includes patient/carer details.

Date / /

Full name

Position title of person signing Section 3.5

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IPTAAS CONTACT DETAILS

For more information about IPTAAS please contact your local IPTAAS office using the details below.

Hunter New England – Tamworth

Phone: 1800 478 227 + Select option 1
Fax: (02) 6766 4576
Email: hnelhd-iptaas@hnehealth.nsw.gov.au
Post: IPTAAS Coordinator
Locked Bag 9783, Tamworth NEMSC NSW 2348

Northern NSW, Mid North Coast – Lismore

Phone: 1800 478 227 + Select option 2
Fax: (02) 6622 1834
Email: tfh-iptaas@ncahs.health.nsw.gov.au
Post: IPTAAS Coordinator
Locked Bag 11, Lismore NSW 2480

Far West – Broken Hill

Phone: 1800 478 227 + Select option 3
Fax: (08) 8080 1695
Email: fwlhd-iptaas@health.nsw.gov.au
Post: IPTAAS Coordinator
Broken Hill Health Service
PO Box 457, Broken Hill NSW 2880

Central Coast, Illawarra Shoalhaven, Murrumbidgee, Nepean Blue Mountains, Northern Sydney, Southern NSW, South Eastern Sydney, South Western Sydney, Sydney, Western NSW, Western Sydney

Phone: 1800 478 227 + Select option 4
Fax: (02) 8797 6543
Email: iptaas@health.nsw.gov.au
Post: IPTAAS Coordinator
Locked Bag 5270
Parramatta NSW 2124

Over the counter services are available at Tamworth, Lismore, Dubbo and Broken Hill.

Alternatively, phone **1800 IPTAAS (1800 478 227)** to speak to one of our friendly customer service staff for details of your nearest office.

1800 IPTAAS (1800 478 227) 9am-5pm weekdays. ABN: 65 697 563 521
iptaas@health.nsw.gov.au | **www.iptaas.health.nsw.gov.au**