Australian Government
Services Australia

medicare

When to use this form

Use this form to claim for paid and unpaid accounts for:

- a **patient** claiming on their own behalf
- an **individual** claiming on behalf of a patient
- a **business or third party** claiming on behalf of a patient.

You must only use this Medicare claim form if you are claiming by mail.

Supporting information

We need the following **original** supporting documents to process your Medicare claim:

- invoices for the services you want to claim
- proof of payment if you paid for the services in full.

Medicare Safety Net

The Medicare Safety Net provides families and individuals with financial assistance for high out-of-pocket costs for out-of-hospital Medicare Benefits Schedule services. For more information or to register, go to **servicesaustralia.gov.au/safetynet** or call **132 011**.

Call charges may apply.

Australian Organ Donor Register

The Australian Organ Donor Register is where you can record your organ and tissue donation decision. For more information or to register, go to **servicesaustralia.gov.au/organdonor** or call **1800 777 203**.

Call charges may apply.

Filling in this form

You can fill this form digitally in some browsers, or you can open it in Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader, you can print this form and complete it.

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this ☐ ▶ *Go to 1* skip to the question number shown.

Patient's details

The patient is the person who received the medical and/or dental service.

1 Patient's Medicare card number

☐☐☐☐ ☐☐☐☐☐ ☐   Ref no. ☐

Medicare claim

2 **Read** this before answering the following question.

The claimant is the individual or business/third party who paid for, or is likely to pay for, the medical and/or dental expense(s). The Medicare benefit(s) will be paid to this individual or business/third party.

Are you: **Tick one only**

a patient claiming on your own behalf ☐ ▶ *Go to 6*

an individual claiming on behalf of a patient ☐ ▶ *Go to 3*

a business or third party claiming ☐ ▶ *Go to 9*
on behalf of a patient

Individual claiming on behalf of a patient

3 Individual claimant's Medicare card number

☐☐☐☐ ☐☐☐☐☐ ☐   Ref no. ☐

4 Individual claimant's name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other ☐

Family name

☐

First given name

☐

5 Individual claimant's date of birth (DD MM YYYY)

☐☐ ☐☐ ☐☐☐☐

MCA0MS014 2309

Contact details

6 Daytime phone number (including area code)

7 Postal address

Postcode

8 Do you want this recorded as your permanent postal address for everyone on your Medicare card?

No ☐

Yes ☐ ▶ *Go to 12*

Business or third party claimant's details

9 Business/third party name **or** executor/administrator name

10 Daytime phone number (including area code)

11 Business or third party postal address

Postcode

Bank account details

12 Where do you want your payment made?

All payments are made through Electronic Funds Transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT deposits.

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

Privacy notice

13 The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacypolicy**

Claimant's declaration

14 **I declare that**:

- I have paid for, or am liable to pay, the expenses for these services.
- I am the executor or administrator acting on behalf of the deceased claimant's estate (if applicable).
- the services were not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with the patient's employment.
- the services were not provided by or on behalf of the Australian Government, a state, territory or a local governing body or an authority established by a law of the Australian Government, a state or territory.
- I have not claimed for dental expenses through private health insurance.
- I have read, understand and agree to the **Privacy notice**.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Claimant's signature

✍

Date (DD MM YYYY)

Returning this form

Return this form, the **original** invoices for the services you want to claim and proof of payment (if you paid for the services in full) by post to:

Services Australia
Medicare
GPO Box 9822
In your capital city