

# Medicare Compensation Recovery Section 23A statement (M0023)

## When to use this form

This form is to be completed by the injured person or claimant (such as a legal representative) after judgment or settlement, where:

- a notice of past benefits has not been issued by Services Australia within the previous 6 months
- they are declaring that **on the date the amount of compensation was fixed, either:**
  - **no eligible benefits** have been received in relation to the injury or illness
  - **no further eligible benefits** have been received in relation to the injury or illness, since the expired notice of past benefits was issued.

This form should be sent to Services Australia **within 28 days after the date** the amount of compensation was fixed.

## Definitions

**Compensation payer** is the person who is liable to make a payment of compensation and can include a notifiable person.

**Injured person** is the person or legal entity in respect of whose injury or illness, the compensation may be paid.

**Claimant** is the person or legal entity making a claim for compensation under the *Health and Other Services (Compensation) Act 1995* (the Act) on behalf of the injured person.

**Authorised third party** is an organisation (such as a law firm) or an individual (such as a friend, relative or legal representative) who has been authorised to act on behalf of the injured person or claimant under the Act.

**Legal representative** is a person who has been appointed by law to act on the injured person's behalf such as an executor, court order, power of attorney. Evidence is required to support the appointment.

**Eligible benefits** include Medicare benefits, nursing home benefits, residential care subsidies or home care subsidies.

The Act is available at [legislation.gov.au](http://legislation.gov.au)

## For more information

Go to [servicesaustralia.gov.au/medicarecompensationrecovery](http://servicesaustralia.gov.au/medicarecompensationrecovery) or call 1800 777 653 Monday to Friday, 8:30 am to 5 pm (local time).

## Information in your language

To speak to us in your language, call **131 202**.

## Hearing and speech assistance

If you have a hearing or speech impairment, you can use:

- the National Relay Service **1800 555 660**, or
- our TTY service on **1800 810 586**. You need a TTY phone to use this service.

For more information about help with communication, go to [servicesaustralia.gov.au](http://servicesaustralia.gov.au) and search 'other support and advice'.

## Filling in this form

You can complete this form on your computer using Adobe Acrobat Reader, or you can print it.

For help on how to fill in our forms, go to [servicesaustralia.gov.au/formhelp](http://servicesaustralia.gov.au/formhelp)

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.

## Compensation case or claim reference numbers

### 1 Compensation case or claim reference numbers (if known)

Medicare	<input type="text"/>
Insurer	<input type="text"/>

## Injured person's details

### 2 Is the injured person listed on a Medicare card?

No ☐

Yes ☐

Provide Medicare card number

Ref no.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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### 3 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other

Family name

First given name

Second given name

### 4 Date of birth (DD MM YYYY)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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### 5 Postal address

<input type="text"/>
<input type="text"/>
<input type="text"/>
Postcode

6 Daytime phone number (including area code)

Mobile phone number

Email

7 Is this form being completed on behalf of the injured person?

No ☐ **Go to 10**

Yes ☐

8 Which of the following best describes the injured person?

**Tick one only**

Younger than 14 ☐

14 or older and does not have the  
capacity to act on their own behalf ☐

Deceased ☐



If this claim is being made on behalf of someone:

- **younger than 14**, the claimant must be a parent or guardian. If both parties are not on the same Medicare card, provide supporting documentation (for example, birth certificate, guardianship order)
- **14 or older who does not have the capacity to act on their own behalf or is deceased**, provide supporting documentation (for example, power of attorney, court order, last will and testament, probate).

9 What is your relationship to the injured person?

**Tick one only**

Parent ☐

Guardian ☐

Legal representative ☐

Public trustee ☐

Other ☐ **Give details below**

## Claim details

10 Date of injury or illness (DD MM YYYY)

If exact date is unknown, write the 1st of the month and year or date of the first treatment. The date of injury must match the one on the case.

11 Provide a brief description of the injury or illness

## Details of compensation payer(s)

### 12 Compensation payer 1

This party will be liable to pay the charge for recoverable benefits and subsidies.

Compensation payer's case reference

Compensation payer's business name

Australian Business Number (ABN)

Postal address

Postcode

Contact person's full name

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

Family name

First given name

Second given name

Contact person's position (for example, claim manager, compensation assessor)

Daytime phone number (including area code)

Email

Solicitor's or agent's case reference

Solicitor's or agent's business name

Australian Business Number (ABN)

Postal address

Postcode

Contact person's full name

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

Family name

First given name

Second given name

Contact person's position (for example, claim manager, compensation assessor)

Daytime phone number (including area code)

Email

No ☐ **Go to 15**  
Yes ☐ *Go to next question*

Compensation payer's case reference <input type="text"/>	
Compensation payer's business name <input type="text"/>	
Australian Business Number (ABN) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Postal address <input type="text"/> <input type="text"/> <input type="text"/>	
<div>Postcode</div> <input type="text"/>	
Contact person's full name Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mx <input type="checkbox"/> Other <input type="text"/>	
Family name <input type="text"/>	
First given name <input type="text"/>	
Second given name <input type="text"/>	
Contact person's position (for example, claim manager, compensation assessor) <input type="text"/>	
Daytime phone number (including area code) <input type="text"/>	
Email <input type="text"/>	

### Compensation payer 2's solicitor or agent (if applicable)

Solicitor's or agent's case reference

Solicitor's or agent's business name

Australian Business Number (ABN)

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Postal address

Postcode

Contact person's full name

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

Family name

First given name

Second given name

Contact person's position (for example, claim manager, compensation assessor)

Daytime phone number (including area code)

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Email

If there are more than 2 compensation payers, provide a separate sheet with details.

### Privacy notice

**15** The privacy and security of your personal information is important to us, and is protected by law. We collect this information so we can process, issue notices and manage the compensation claim under the *Health and Other Services (Compensation) Act 1995*. Your personal and sensitive information may be disclosed to the injured person, claimant, legal representative, authorised third party, compensation payer, notifiable person or the Department of Health, Disability and Ageing.

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](https://servicesaustralia.gov.au/privacypolicy)

### Declaration

#### 16 I declare that:

- on the date the amount of compensation was fixed, where a notice of past benefits has
  - never been issued, that no Medicare benefit, nursing home benefit, residential care subsidy or home care subsidy has been paid in the course of treatment for, or as a result of, the injury or illness, **or**
  - previously been issued, that no further Medicare benefit, nursing home benefit, residential care subsidy or home care subsidy has been paid in the course of treatment for, or as a result of, the injury or illness
- the information I have provided in this form is complete and correct.

#### I understand that:

- giving false or misleading information is a serious offence.

Injured person's or claimant's full name

Injured person's or claimant's signature

Date of signature (DD MM YYYY)

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### Returning this form

Check that all required questions are answered and the form is signed and dated. Incomplete forms will not be processed. Edits or additions to previously submitted forms will not be accepted.

Return the completed form and any supporting documents by:

- email to**  
**[compensation.recovery@servicesaustralia.gov.au](mailto:compensation.recovery@servicesaustralia.gov.au)**  
There may be risks with sending personal information through unsecured networks or email channels.
- post to**  
Services Australia  
Medicare Compensation Recovery  
GPO Box 2436  
BRISBANE QLD 4001