



8 Are you requesting personal or family claims information?

Personal only  **Go to 14**

Family only

Personal and family

### Family members aged 14 years and over

9 Are you requesting information about other family members aged 14 years or over?

No  **Go to 10**

Yes

Complete question 9 if information is required for other family members aged 14 years and over.

Information requested for family members aged 14 years and over, must be accompanied by their signature.

If the other family members are not listed on your Medicare card they will need to submit a separate request.

#### Family member 1

Dr  Mr  Mrs  Miss  Ms  Mx  Other

Family name

First given name

Second given name

Date of birth (DD MM YYYY)

  

Would you like us to send your personal information to a third party?

No

Yes  I authorise Services Australia to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

  
  
  

Postcode

Family member 1 signature

Date (DD MM YYYY)

  

#### Family member 2

Dr  Mr  Mrs  Miss  Ms  Mx  Other

Family name

First given name

Second given name

Date of birth (DD MM YYYY)

  

Would you like us to send your personal information to a third party?

No

Yes  I authorise Services Australia to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

  
  
  

Postcode

Family member 2 signature

Date (DD MM YYYY)

  

If the information relates to more than 2 additional family members aged 14 years and over, provide a separate sheet with details.

## Requests for children under 14 years of age

A person with parental responsibility can generally get Medicare or PBS information about a child where the child is under 14 years of age and listed on the same Medicare card as the requesting person.

**10** Are you requesting information for a child under 14 years of age?

No  **Go to 14**  
Yes

**11** Are you the child's parent or guardian?

No  You may not request this claims information  
Yes  If legal guardian, provide supporting documents

### Child 1

Family name	<input type="text"/>
First given name	<input type="text"/>
Second given name	<input type="text"/>
Other names child known by (if applicable)	<input type="text"/>
Date of birth (DD MM YYYY)	<input type="text"/> <input type="text"/> <input type="text"/>
Is the child a subject of Family Court orders?	No <input type="checkbox"/> Yes <input type="checkbox"/> Provide a copy of the current court order.
Is the child listed on more than one Medicare card?	No <input type="checkbox"/> Yes <input type="checkbox"/> Provide details
Child's other Medicare card number	<input type="text"/> <input type="text"/> <input type="text"/> Ref no. <input type="text"/>
Child's other address (if applicable)	<input type="text"/> ..... ..... Postcode

### Child 2

Family name	<input type="text"/>
First given name	<input type="text"/>
Second given name	<input type="text"/>
Other names child known by (if applicable)	<input type="text"/>
Date of birth (DD MM YYYY)	<input type="text"/> <input type="text"/> <input type="text"/>
Is the child a subject of Family Court orders?	No <input type="checkbox"/> Yes <input type="checkbox"/> Provide a copy of the current court order.
Is the child listed on more than one Medicare card?	No <input type="checkbox"/> Yes <input type="checkbox"/> Provide details
Child's other Medicare card number	<input type="text"/> <input type="text"/> <input type="text"/> Ref no. <input type="text"/>
Child's other address (if applicable)	<input type="text"/> ..... ..... Postcode

### Child 3

Family name	<input type="text"/>
First given name	<input type="text"/>
Second given name	<input type="text"/>
Other names child known by (if applicable)	<input type="text"/>
Date of birth (DD MM YYYY)	<input type="text"/> <input type="text"/> <input type="text"/>
Is the child a subject of Family Court orders?	No <input type="checkbox"/> Yes <input type="checkbox"/> Provide a copy of the current court order.
Is the child listed on more than one Medicare card?	No <input type="checkbox"/> Yes <input type="checkbox"/> Provide details
Child's other Medicare card number	<input type="text"/> <input type="text"/> <input type="text"/> Ref no. <input type="text"/>
Child's other address (if applicable)	<input type="text"/> ..... ..... Postcode

If the information relates to more than 3 children under 14 years of age, provide a separate sheet with details.

**12** Would you like us to send your child's/children's personal information to a third party?

No  **Go to 14**

Yes

**13** I authorise Services Australia to provide my child's/children's personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

  .....  .....  Postcode
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### Authorisation

**14** Would you like us to send your personal information to a third party?

No  **Go to 16**

Yes

**15** I authorise Services Australia to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

  .....  .....  Postcode
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### Privacy notice

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

### Declaration

**17** I declare that:

- I have parental responsibility for each child under 14 years of age for whom I have requested claims information
- the information I have provided in this form is complete and correct.

**I understand that:**

- giving false or misleading information is a serious offence.

Applicant's signature


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Date (DD MM YYYY)

<input type="text"/>					
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### Returning this form

Check that all required questions are answered and that the form is signed and dated.

If you have indicated that the information requested in this form should be provided to a third party, return this completed form to that third party.

The third party is responsible for returning this completed form and any supporting documents:

- **email to [medicare.disclosure@servicesaustralia.gov.au](mailto:medicare.disclosure@servicesaustralia.gov.au)**  
There may be risks with sending personal information through unsecured networks or email channels.
- in person at one of our service centres.