



Australian Thalidomide Survivors Support Program Health Care Assistance Fund

When to use this form



Use this form to apply for:

- pre-approval of a quote(s) for goods or services yet to be received, or
- reimbursement of an invoice(s) for goods or services received

that are covered by the Health Care Assistance Fund (HCAF). To read the *Extraordinary Assistance Fund (EAF) and Health Care Assistance Fund (HCAF) Program Guidelines*, go to **health.gov.au**

To claim for the HCAF, you must:

- be an Australian citizen or a permanent resident and have current Medicare entitlement
- be registered with the Australian Thalidomide Survivors Support Program
- provide evidence from a registered health care practitioner that the goods or services are required as a likely consequence of thalidomide related injuries, and
- have already claimed from Medicare, the Pharmaceutical Benefits Scheme (PBS) or other relevant Australian, state or territory government scheme, or private insurance, where appropriate.

If you want to claim costs relating to daily living, home or vehicle modifications, you will need to complete the **Australian Thalidomide Survivors Support Program Extraordinary Assistance Fund (PB299)** form. To download the form, go to **servicesaustralia.gov.au/forms** or email **thalidomide.claims@servicesaustralia.gov.au**. There may be risks with sending personal information through unsecured networks.

Online account



You can upload this form, with any supporting documents, using your **Medicare online account** through myGov. Sign in to **my.gov.au** and go to **Services**, then select **Medicare**.

If you do not have a myGov account, go to **my.gov.au** and create one. For help, go to **servicesaustralia.gov.au/onlineguides**

What else you will need to provide

Health care practitioner evidence

You must provide written evidence from a registered health care practitioner with this claim. This evidence should include the:

- health care practitioner's details, including their name, address and provider number
- date you were assessed by the registered health care practitioner
- type of goods or services needed, including the frequency and duration of the service (if applicable)
- goods or services recommended as a likely consequence of thalidomide related injuries.

For more information



Go to **servicesaustralia.gov.au/thalidomide** or call the Thalidomide Support Service on 1800 643 787 Monday to Friday, 8 am to 5 pm, Australian Eastern Standard Time.

Information in your language

We can translate documents you need for your claim or payment for free.

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** and search 'other support and advice'.



Australian Thalidomide Survivors Support Program Health Care Assistance Fund (PB300)

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**

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.

Claimant's details

1 Medicare card number

<input type="text"/>	<input type="text"/>	<input type="text"/>	Ref no. <input type="text"/>
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2 Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other

Family name

First given name

3 Has your postal address changed since your last claim?

No ☐ **Go to next question**

Not sure ☐ **Give details below**

Yes ☐ **Give details below**

We will use this to update your Medicare records.

Postal address

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

4 Home phone number (including area code)

Mobile phone number

Email

Authorised representative

5 Read this before answering the following questions.

These questions tell us if you have authorised or would like to authorise a person to complete HCAF claim forms or talk to staff about your HCAF claim(s) on your behalf.

This does **not** authorise the nominated person to change your contact details.

From the date this form is submitted, the person you nominate below will be authorised to complete HCAF claim forms or talk to staff about your claim(s) on your behalf.

Only one person can be nominated at a time.

You can still deal with us, even if you have authorised a person to help you.

If you want to change these details or if you think the access you have given a person is being misused, email **thalidomide.claims@servicesaustralia.gov.au**

There may be risks with sending personal information through unsecured networks or email channels.

Have you authorised a person to complete HCAF claim forms or talk to staff about your claim(s) on your behalf?

No ☐ **Go to next question**

Yes ☐ **Go to 7**

6 Do you want to authorise a person to complete HCAF claim forms or talk to staff about your claim(s) on your behalf?

No ☐ **Go to next question**

Yes ☐ **Give details below**

Details of your authorised representative

Family name

First given name

Date of birth (DD MM YYYY)

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

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

Home phone number (including area code)

Work phone number (including area code)

Mobile phone number

What is the relationship of the authorised representative to you?

Tick one only

Carer ☐

Family member ☐

Power of attorney ☐

Other ☐ Give details below

Details of the goods or services

7 What is the claim for?

Tick all that apply

Pre-approval of a quote ☐ **Go to 8 on page 4**
for goods or services

Reimbursement for goods ☐ **Go to 9 on page 6**
or services you received
and paid, or part paid, for

Pre-approval of quote for goods or services

Read this before answering the following questions.

When your claim has been assessed and approved, you will receive a letter with a pre-approval reference number. Once the goods or services have been received, return the letter with your invoice(s) or receipt(s) so payment can be made.

- 8** Are you seeking **pre-approval of a quote** for goods or services that you have **not yet received or paid for**?

No ***Go to 9***

Yes ☐ Give details below

If you are seeking more than 2 pre-approvals, copy this page for each extra request or provide a separate sheet with details.

Pre-approval 1	Goods or services quoted

- 8A** What goods or services do you need pre-approval for?

Tick one only

Health products ☐Pharmaceuticals ☐Health services – allied health ☐Health services – medical ☐Health services – dental ☐Travel and accommodation ☐

Other ☐ Give details below

Description of goods or services

- 8B** I am seeking pre-approval of the quote from:

Name of person or business

--

Contact phone number for person or business
(including area code)

A horizontal number line with 10 equally spaced tick marks. The line is enclosed in a rectangular box. The tick marks are vertical lines extending both above and below the horizontal line. There are no numbers or labels on the line.

ABN for person or business

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Date of quote (DD MM YYYY)

Value of quote

\$

Pre-approval 1	<i>Continued</i>
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- 8C** If you have received more than one quote, tell us below why you have selected this quote (for example, price, describe value for money, provides a specific service).



Provide copies of all quotes received with your claim.

- 8D** Do you want pre-approval of a quote for other goods or services?

No  **Go to 8E**

Yes ☐ **Go to Pre-approval 2 – 8A**

- 8E** Do you want to claim for reimbursement of goods or services received?

No  **Go to 12**

Yes ☐  ***Go to 9 on page 6***

Pre-approval 2	Goods or services quoted

8A What goods or services do you need pre-approval for?

Tick one only

Health products ☐Pharmaceuticals ☐

Health services – allied health ☐

Health services – medical ☐Health services – dental ☐Travel and accommodation ☐

Other ☐ Give details below

Description of goods or services

8B I am seeking pre-approval of the quote from:

Name of person or business

--

Contact phone number for person or business
(including area code)

[illegible]

ABN for person or business

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Date of quote (DD MM YYYY)

1

2

3

Value of quote

\$ _____

8C If you have received more than one quote, tell us below why you have selected this quote (for example, price, describe value for money, provides a specific service).



Provide copies of all quotes received with your claim.

Pre-approval 2 *Continued*

8D Do you want pre-approval of a quote for other goods or services?

No  ***Go to 8E***

Yes ☐ **Go to 8E**

8E Do you want to claim for reimbursement of goods or services received?

No ***Go to 12***

Yes ☐ ***Go to 9 on page 8***

If you need more space, provide a separate sheet with details.

Bank details

- 9 Do you want your reimbursement, for goods or services received, made to the same account you receive your Medicare payments?

No ☐ ► *Go to next question*

Yes ☐ ► **Go to 11A**

- 10 Where do you want your payments for claims to the HCAF made?

Any bank details provided in this form will result in all Medicare payments being paid to this account.

All payments are made through electronic funds transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT deposits.

Payments cannot be made to an account used exclusively for funding from the National Disability Insurance Scheme (NDIS).

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be your card number)

Account held in the name(s) of

If you have more than 2 claims, copy this page for each additional claim or provide a separate sheet with details.

Yes ☐ **Go to Claim 2 – 11A**

Claim 2 Reimbursement for goods or services received

11A Do you have a pre-approval number for the goods or services you are claiming?

No  **Go to 11B**

Yes ☐ Pre-approval number

► **Go to 11D**

11B What goods or services have you **received**?

Tick one only

Health products ☐Pharmaceuticals ☐Health services – allied health ☐Health services – medical ☐Health services – dental ☐Travel and accommodation ☐

Other ☐ Give details below

Description of goods or services received

Date you received the goods or services

(DD MM YYYY)

Total cost of the goods or services you received

\$ _____

11C Who provided the goods or services?

Name of person or business

--

Contact phone number for person or business
(including area code)

[illegible]

ABN for person or business

Four empty rectangular boxes are provided for drawing. Each box is a simple rectangle with a thin black border. The first box is on the left, followed by three more boxes to its right, all separated by small gaps. These boxes are intended for the student to draw the objects they identified in the previous step.

Claim 2 *Continued*

11D Have you received any reimbursement or payments for the goods or services you are claiming?


No  **Go to 11E**

Yes ☐ Give details below

NDIS	\$
Medicare	\$
PBS	\$
Private health fund	\$
Any other relevant Australian, state or territory government scheme	\$
Other, give details below	
	\$
	\$
	\$

11E Amount you are claiming from the HCAF for the goods or services received after any reimbursements (if applicable)

\$

 Provide copies of tax invoices or receipts with your claim.

11F Do you want to claim for another reimbursement?

No ☐Yes ☐

If you need more space, provide a separate sheet with details.

12 Who completed this form?

Tick all that apply

Claimant ☐ As the claimant, you are to sign at **question 15**

► Go to next question

Authorised representative ☐ As the authorised representative, you are to sign at **question 16**



Provide supporting documentation that demonstrates the authority. For example, power of attorney or appropriate medical evidence from a registered health care practitioner.

► Go to next question

Checklist

13 Which of the following documents are you providing with this form?

Where you are asked to supply documents, provide original documents. In some circumstances, copies may be accepted as detailed in the below checklist.

If you are not sure, check the question to see if you should provide the documents.

Evidence from a registered health care practitioner (mandatory) ☐

(see **Health care practitioner evidence** on page 1)

Copies of all quotes for goods or services – for pre-approval documentation requirements, refer to the *Extraordinary Assistance Fund (EAF) and Health Care Assistance Fund (HCAF) Program Guidelines* (If required at **question 8C**) ☐

Copies of receipts or tax invoices (If required at **question 11E**) ☐

Supporting documentation that demonstrates the authority. For example, power of attorney or appropriate medical evidence from a registered health care practitioner (If required at **question 12**) ☐

Privacy notice

14 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

► Questions continue

Claimant's declaration

15 I declare that:

- I am registered and eligible to receive help under the Australian Thalidomide Survivors Support Program
- I am the recipient of the goods or services being claimed
- the goods or services being claimed are required as a likely consequence of my thalidomide related injury(ies), covered by the Australian Thalidomide Survivors Support Program as outlined in the *Extraordinary Assistance Fund (EAF) and Health Care Assistance Fund (HCAF) Program Guidelines*
- all other entitlements and benefits, for example, private health fund, Medicare, Pharmaceutical Benefits Scheme, National Disability Insurance Scheme or other government support, have been claimed where possible
- all out-of-pocket expenses claimed by me relate to goods or services for which I am entitled to claim a payment under the Australian Thalidomide Survivors Support Program
- the information I have provided in this form is complete and correct.


I understand that:

- benefits are provided under the Australian Thalidomide Survivors Support Program as a result of information that I have provided
- a random audit of claims made to the Health Care Assistance Fund will be undertaken
- I am required to keep copies of relevant records for a minimum of 5 years for auditing purposes
- giving false or misleading information is a serious offence and may result in Services Australia recovering benefits provided by the Australian Thalidomide Survivors Support Program.

I consent to:

- Services Australia collecting, using and disclosing information about me (including my Medicare information) to:
 - verify if I have claimed or received other entitlements and benefits (including private health fund, Medicare, National Disability Insurance Scheme or other government support)
 - verify information provided by a third party for the purposes of assessing my claim under the Australian Thalidomide Survivors Support Program.

Claimant's signature



Date (DD MM YYYY)

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Authorised representative's declaration

16 Authorised representative acceptance

I declare that:

- the claimant is registered and eligible to receive help under the Australian Thalidomide Survivors Support Program
- the claimant is the recipient of the goods or services being claimed
- the goods or services being claimed are required as a likely consequence of the claimant's thalidomide related injury(ies), covered by the Australian Thalidomide Survivors Support Program as outlined in the *Extraordinary Assistance Fund (EAF) and Health Care Assistance Fund (HCAF) Program Guidelines*
- all other entitlements and benefits, for example, private health fund, Medicare, National Disability Insurance Scheme or other government support, have been claimed by the claimant where possible
- all out-of-pocket expenses claimed by the claimant relate to goods or services for which the claimant is entitled to claim a payment under the Australian Thalidomide Survivors Support Program
- I understand and accept the responsibilities and obligations to act on behalf of and in the best interests of the claimant
- the information I have provided in this form is complete and correct.

I understand that:

- any personal information I am given access to under this type of access is protected under Commonwealth legislation. I agree to access, use or disclose the information only as authorised by the person to whom the information relates
- benefits are provided under the Australian Thalidomide Survivors Support Program as a result of information that I have provided
- a random audit of claims made to the Health Care Assistance Fund will be undertaken
- I am required to keep copies of relevant records for a minimum of 5 years for auditing purposes
- giving false or misleading information is a serious offence and may result in Services Australia recovering benefits provided by the Australian Thalidomide Survivors Support Program.

Name of authorised representative

Authorised representative's signature



Date (DD MM YYYY)

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Returning this form

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

Return this form and all supporting documents:

- **online** using your Medicare online account through myGov.
- by email to **thalidomide.claims@servicesaustralia.gov.au**
There may be risks with sending personal information through unsecured networks or email channels.
- by post to Services Australia, Australian Thalidomide Survivors Support Program, PO Box 9822, In your capital city