Australian Government
Department of Human Services

medicare

Medicare Compensation Recovery Section 23A statement (MO023)

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 the Australian Government Department of Human Services 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 forwarded to Human Services **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 or insurer.

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

Claimant is the person seeking compensation either on his or her own behalf or on behalf of another person.

Legal representative is the person who has been appointed by law to act on the injured person's behalf (such as an executor, court order, Power of Attorney).

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

For more information

Go to **humanservices.gov.au/medicarecompensationrecovery** or email **compensation.recovery@humanservices.gov.au** or call **132 127**.

Note: Call charges may apply.

Filling in this 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. You do not need to answer the questions in between.

Injured person's details

1 Is the injured person listed on a Medicare card?

No ☐

Yes ☐▶ Provide Medicare card number ______ – ______ – ___ Ref no. ___

2 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ______

Family name

First given name

Second given name

3 Date of birth

/ /

4 Postal address

Postcode

5 Daytime phone number

( )

Mobile phone number

6 Is this form being completed on behalf of the injured person who:

- is under 14 years of age
- does not have the capacity to act on their own behalf, **or**
- is deceased?

No ☐ ▶ ***Go to 10***

Yes ☐ ▶ Give details of the relationship to the injured person (for example, parent, guardian or legal representative)

If this claim is being made on behalf of someone **14 years of age or over who does not have the capacity to act on their own behalf or is deceased**, provide supporting documentation (Power of Attorney, court order, Last Will and Testament or probate).

▶ *Go to next question*

Claimant's details

7 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name or business name (if applicable)

First given name

Second given name

8 Postal address

Postcode

9 Daytime phone number

( )

Mobile phone number

Medicare compensation case reference number

10 Has this compensation case previously been registered with Human Services?

No ☐

Yes ☐ ▶ Provide the Medicare compensation case reference number

▶ ***Go to 16***

Claim details

11 Date of injury or illness

/ /

12 Provide a brief description of the injury or illness

Compensation payer's details

13 **Compensation payer 1**

Compensation payer's case reference

Compensation payer's business name

Postal address

Postcode

Daytime phone number

Compensation payer 1's solicitor

Solicitor's case reference

Solicitor's business name

Postal address

Postcode

Daytime phone number

14 Is there more than one compensation payer?

No ☐ ▶ ***Go to 16***

Yes ☐ ▶ *Go to next question*

15 Compensation payer 2

Compensation payer's case reference

Compensation payer's business name

Postal address

Postcode

Daytime phone number

Compensation payer 2's solicitor

Solicitor's case reference

Solicitor's business name

Postal address

Postcode

Daytime phone number

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

Privacy notice

16 Your personal information, and the personal information of others that you provide, is protected by law, including the *Privacy Act 1988*. The Australian Government Department of Human Services collects this personal information for the purposes of administering the *Health and Other Services (Compensation) Act 1995*. Human Services may collect personal information about the injured person from the injured person's and/or claimant's authorised third party and from the relevant notifiable person or compensation payer.

Human Services may disclose the injured person's personal and sensitive information to the claimant, authorised third party and the relevant notifiable person or compensation payer. Information that may be disclosed includes information contained in a Medicare history statement, notice of past benefits and notice of charge, as well as information about relevant events relating to the injured person's compensation claim. In addition, Human Services may disclose the injured person's personal and sensitive information to the Department of Health for the purposes of determining the injured person's eligibility for payments and services under the *Aged Care Act 1997*.

Your information may be used by Human Services or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which Human Services will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy** or by requesting a copy from Human Services.

Declaration

17 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**
- where a notice of past benefits has 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, **and**
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence under the *Criminal Code Act 1995*.

Injured person's or claimant's full name

Injured person's or claimant's signature

✍

Date

/ /

Returning your form

Check that all required questions are answered and that the form is signed and dated. Answering all questions may not be required, however where required information is incomplete, it may cause processing delays.

Return the completed form and any supporting documents by:

- **email** to **compensation.recovery@humanservices.gov.au**
  Note: There may be risks associated with sending personal information through unsecured networks or email channels.
- **fax** to **07 3004 5406**
- **post** to **Department of Human Services**
  Medicare Compensation Recovery
  GPO Box 2436
  BRISBANE QLD 4001