Australian Government
Services Australia

medicare

Medicare Compensation Recovery Notice of reimbursement arrangement (M0027)

When to use this form

This form is to be completed by the compensation payer or compensation payer's solicitor if a reimbursement arrangement was made **6 months after** the compensation claim was lodged by the injured person or claimant (such as a legal representative). The compensation payer must advise Services Australia **within 28 days** after the reimbursement arrangement is made.

A reimbursement arrangement is either:

- an agreement in writing
- an order by a court or compensation authority
- a decision that the person against whom a claim for compensation is made is liable to pay compensation to reimburse the injured person for expenses and eligible benefits as they are incurred.

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 and home care subsidies.

For more information

Go to **servicesaustralia.gov.au/medicarecompensationrecovery** or email **compensation.recovery@servicesaustralia.gov.au** or call **132 127** Monday to Friday, 8:30 am to 5 pm, Australian Eastern Standard Time.

Call charges may apply.

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

Filling in this form

You can fill and sign this form digitally. You can do this by downloading it on your computer or a device that has Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader you can print it and sign it by hand.

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.

Medicare compensation case reference number

1 Provide the Medicare compensation case reference number (if known)

2 Has a reimbursement arrangement been made?

No ☐ STOP Do not complete this form. Refer to **Medicare Compensation Recovery Medicare history statement request (M0026)** form.

Yes ☐

3 Does this notice relate to a compensation claim under a Bulk Payment Agreement?

No ☐

Yes ☐ STOP Do not complete this form. A completed Medicare history statement is not required as a notice of charge will not be issued. Please contact the notifiable person for the Bulk Payment Agreement.

4 Has 6 months passed since the claim was lodged?

No ☐ STOP You are not required to notify us.

Yes ☐ Provide the date the claim for compensation was lodged

/ /

Provide the date the reimbursement arrangement was made

/ /

If based on an appeal decision, provide a copy of these documents.

5 Is the injured person listed on a Medicare card?

No ☐ *Go to next question*

Yes ☐ ***Go to 7***

6 Has the injured person received any nursing home benefits, residential care or home care subsidies relating to this claim?

No ☐ STOP As the injured person is not listed on a Medicare card and has not received any care costs in relation to this claim, you are **not required to complete this form** or notify us of this case.

Yes ☐ ***Go to 8***

Injured person's details

7 Medicare card number (if known)

[ ][ ][ ][ ] – [ ][ ][ ][ ][ ] – [ ] Ref no. [ ]

8 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other [ ]

Family name

First given name

Second given name

9 Date of birth

/ /

10 Postal address

Postcode

11 Daytime phone number

( )

Mobile phone number

Claim details

12 Date of injury or illness

/ /

13 Give a brief description of the injury or illness

14 Type of compensation being claimed:

Tick one only

Workers' compensation ☐

Motor vehicle accident ☐

Transport Accident Commission ☐

Common law ☐

Public liability ☐

Other ☐ Give details below

15 Was the reimbursement arrangement made 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 19***

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

If this reimbursement arrangement was 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, probate).

▶ *Go to next question*

Claimant's details

16 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other [ ]

Family name or business name (if applicable)

First given name

Second given name

17 Postal address

Postcode

18 Daytime phone number

( )

Mobile phone number

Details of the injured person's solicitor or authorised third party

If the injured person or claimant wishes to give Services Australia authority to release compensation information to their solicitor or a third party and give permission for them to sign relevant documentation on their behalf, they should complete the **Medicare Compensation Recovery Third party authority (MO021)** form.

19 Solicitor's or authorised third party's case reference

20 Solicitor's business name or authorised third party's full name

21 Postal address

Postcode

22 Daytime phone number

Compensation payer's details

23 Compensation payer's case reference

24 Compensation payer's business name

25 Postal address

Postcode

26 Daytime phone number

Details of the compensation payer's solicitor

27 Solicitor's case reference

28 Solicitor's business name

29 Postal address

Postcode

30 Daytime phone number

If there is more than 1 compensation payer, provide a separate sheet with details.

Payment details

31 To make a payment by Electronic Funds Transfer (EFT), make payment to:

BSB: **092 300**

Account number: **Your allocated unique account number**

Account name: **Services Australia Official Recovery of Compensation for Health Care and other services special account**

You **must** include the compensation case reference number or Medicare card number in the payer reference field.

If you are making payments for individual or multiple claimants, clearly identify each individual case.

Email **all** remittance advices to **medicare.compensation.finance@servicesaustralia.gov.au**
If you do not have or know your allocated unique account number, you may request one by emailing to the same address.

Privacy notice

32 Your personal information, and the personal information of others that you provide, is protected by law, including the *Privacy Act 1988*. Services Australia collects this personal information for the purposes of administering the *Health and Other Services (Compensation) Act 1995*. Services Australia 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.

Services Australia 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, Services Australia 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 Services Australia 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 Services Australia will manage your personal information, including our privacy policy, at **servicesaustralia.gov.au/privacy**

Declaration

33 **I declare that**:

- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Compensation payer's or compensation payer's solicitor's full name

Compensation payer's or compensation payer's solicitor's signature

On completion, insert digital signature or print and sign by hand.

Date

/ /

Reset form Print form

This form is **ONLY VALID** if signed by the compensation payer or compensation payer's solicitor.

Returning this 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@servicesaustralia.gov.au** There may be risks with sending personal information through unsecured networks or email channels.
- by fax to: **07 3004 5406**
- by post to:
  Services Australia
  Medicare Compensation Recovery
  GPO Box 2436
  BRISBANE QLD 4001