Australian Government
Services Australia

Australian Thalidomide Survivors Support Program Health Care Assistance Fund

When to use this form

Use this form to:
- apply for pre-approval of quote(s) for goods and/or services (yet to be received) for out of pocket health care expenses directly associated with thalidomide related injuries and/or
- apply for reimbursement of invoice(s) for goods and/or service(s) received

that are covered by the Health Care Assistance Fund (HCAF) – refer to the *Extraordinary Assistance Fund (EAF) and 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 and/or services are required as a direct consequence of your thalidomide related injuries, and
- have already claimed from Medicare, the Pharmaceutical Benefits Scheme and/or other relevant Australian, state or territory government schemes, or private insurance, where appropriate.

If you would like to claim for costs relating to daily living, home or vehicle modifications, you will need to complete the **Extraordinary Assistance Fund (PB299)** form. To get a copy of this form, go to **servicesaustralia.gov.au/forms** email **thalidomide.claims@servicesaustralia.gov.au** or call the Thalidomide Support Service on **1800 643 787**.

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

Online account

You can upload this form, with any supporting documents, online using your Medicare online account through myGov. For help, go to **servicesaustralia.gov.au/selfservice** and select Medicare.

If you do not have a myGov account, you can create one at **my.gov.au** and link it to your Medicare online account.

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 document information such as the:
- health care practitioner's details, including name, address and provider number
- date you were assessed by the registered health care practitioner
- type of goods and/or services required, including, if applicable, the frequency and duration of the service, and
- goods and/or services recommended are required as a direct result of thalidomide related injuries.

For more information

Read the *EAF and HCAF Program Guidelines* and guiding principles, including an outline of the eligible and ineligible goods and/or services. Go to **health.gov.au**

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

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

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

Call charges may apply.

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 Government
Services Australia

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

Filling in this form

You can fill and sign this form digitally in some browsers, or you can open it in Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader, you can print this form and sign it.

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

Ref no.

2 Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

3 Has your postal address changed since your last claim with Medicare?

No ☐ ▶ *Go to next question*

Not sure ☐ ▶ Give details below

Yes ☐ ▶ Give details below

We will use this to update your Medicare address.

Postal address

Postcode

4 Contact details

Home phone number (including area code)

Mobile phone number

Email

Authorised representative

5 **Read** this before answering the following questions.

This question is to tell us if you 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 assist 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 associated with sending personal information through unsecured networks or email channels.

Have you **previously** authorised a person to complete HCAF claim forms or talk to staff about your claims 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 claims 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)

Postal address

Postcode

Contact phone details

Home phone number (including area code)

Work phone number (including area code)

Mobile phone number

Relationship of the authorised representative to you

Tick one only

Carer ☐
Family member ☐
Power of attorney ☐
Other ☐ ▶ Give details below

Supporting documentation that demonstrates the authority will be required at question 12 (if applicable)

Details of the goods and/or services

7 What is the claim for?

Tick all that apply

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

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

Pre-approval of a quote for required goods and/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 and/or services have been received, return the letter with your invoice(s) and/or receipt(s) so payment can be made.

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

For pre-approval documentation requirements, refer to the *EAF and HCAF Program Guidelines*.

No ☐ ▶ ***Go to 9***

Yes ☐ ▶ Give details below

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

Pre-approval 1 Goods and/or services **quoted**

8A What goods and/or services are you seeking pre-approval of a quote 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 and/or services

Pre-approval 1 *Continued*

8B Provide details of the quote you are seeking pre-approval for.

I am seeking pre-approval of the quote from:

Name of person and/or business

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

ABN for person and/or business

Date of quote (DD MM YYYY)

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.

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

No ☐ ▶ ***Go to 8E***

Yes ☐ ▶ If you are seeking more than 2 pre-approvals, (if you have not already copied page 4) copy page 5 for each additional request or provide a separate sheet with details.

▶ ***Go to Pre-approval 2 – 8A***

8E Do you also want to claim for a reimbursement of goods and/or services received?

No ☐ ▶ ***Go to 12***

Yes ☐ ▶ If you have more than 2 invoices for payment, copy page 7 for each additional invoice or provide a separate sheet with details.

▶ ***Go to 9 on page 6***

Pre-approval 2 Goods and/or services **quoted**

8A What goods and/or services are you seeking pre-approval of a quote 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 and/or services

8B Provide details of the quote you are seeking pre-approval for.

I am seeking pre-approval of the quote from:

Name of person and/or business

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

ABN for person and/or business

Date of quote (DD MM YYYY)

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 and/or services?

No ☐ ▶ ***Go to 8E***

Yes ☐ ▶

If you are seeking more than 2 pre-approvals, provide a separate sheet with details.

▶ ***Go to 8E***

8E Do you also want to claim for a reimbursement of goods and/or services received?

No ☐ ▶ ***Go to 12***

Yes ☐ ▶ If you have more than 2 invoices for payment, copy page 7 for each additional invoice or provide a separate sheet with details.

▶ ***Go to 9 on page 8***

Bank details

9 Do you want your reimbursement, for goods and/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.

The bank, building society or credit union account must be in your name. A joint account is acceptable. Payments cannot be made to credit card, loan or mortgage accounts.

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

Read this before answering the following questions.

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

Claim 1 **Reimbursement** for goods and/or services **received**

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

No ☐ ▶ ***Go to 11B***

Yes ☐ ▶ Pre-approval number

▶ ***Go to 11D***

11B What goods and/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 and/or services received

Date you received the goods and/or services

(DD MM YYYY)

Total cost of the goods and/or services you have received

$

11C Who provided the goods and/or services?

Name of person and/or business

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

ABN for person and/or business

Claim 1 *Continued*

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

No ☐ ▶ ***Go to 11E***

Yes ☐ ▶ Give details below

NDIS	$
Medicare	$
Pharmaceutical Benefits Scheme	$
Private health fund	$
Any other relevant Australian, state or territory government schemes	$
Other, give details below	
	$
	$
	$

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

$

Provide copies of tax invoices and/or receipts with your claim.

11F Do you want to claim for another reimbursement?

No ☐ ▶ ***Go to 12***

Yes ☐ ▶ If you have more than 2 claims, (if you have not already copied page 7) copy page 8 for each additional claim or provide a separate sheet with details.

▶ ***Go to Claim 2 – 11A***

Claim 2 **Reimbursement** for goods and/or services **received**

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

No ☐ ▶ ***Go to 11B***

Yes ☐ ▶ Pre-approval number

▶ ***Go to 11D***

11B What goods and/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 and/or services received

Date you received the goods and/or services

(DD MM YYYY)

Total cost of the goods and/or services you have received

$

11C Who provided the goods and/or services?

Name of person and/or business

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

ABN for person and/or business

Claim 2 *Continued*

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

No ☐ ▶ ***Go to 11E***

Yes ☐ ▶ Give details below

NDIS	$
Medicare	$
Pharmaceutical Benefits Scheme	$
Private health fund	$
Any other relevant Australian, state or territory government schemes	$
Other, give details below	
	$
	$
	$

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

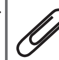
$

Provide copies of tax invoices and/or receipts with your claim.

11F Do you want to claim for another reimbursement?

No ☐ ▶ ***Go to 12***

Yes ☐ ▶


If you have more than 2 claims, provide a separate sheet with details.

▶ ***Go to 12***

12 Who completed this form?

Tick all that apply

Claimant ☐ ▶ You (claimant) are to sign at **question 15**

▶ *Go to next question*

Authorised representative ☐ ▶ You (authorised representative) 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.

Document	
Evidence from a registered health care practitioner (mandatory) (see **Health care practitioner evidence** on page 1)	☐
Copies of all quotes for goods and/or services – for pre-approval documentation requirements, refer to the *EAF and HCAF Program Guidelines*. (If required at **question 8C**)	☐
Copies of receipts and/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 assistance under the Australian Thalidomide Survivors Support Program.
- I am the recipient of the goods and/or services being claimed.
- the goods and/or services being claimed are required as a direct result of my thalidomide related injury(ies), covered by the Australian Thalidomide Survivors Support Program as outlined in the *Extraordinary Assistance Fund and Health Care Assistance Fund 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 and/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.
- 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 and/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)

Authorised representative's declaration

16 Authorised representative acceptance

I declare that:

- the claimant is registered and eligible to receive assistance under the Australian Thalidomide Survivors Support Program.
- the claimant is the recipient of the goods and/or services being claimed.
- the goods and/or services being claimed are required as a direct result of the claimant's thalidomide related injury(ies), covered by the Australian Thalidomide Survivors Support Program as outlined in the Extraordinary Assistance Fund and Health Care Assistance Fund 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 and/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.
- 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)

Returning this form

Check that 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