Australian Government
Services Australia

medicare

Medicare Compensation Recovery Third party authority (M0021)

When to use this form

This form is to be completed by the injured person or claimant (such as a legal representative) who is seeking compensation on behalf of the injured person.

By completing this form, the injured person or claimant gives Services Australia authority to release compensation information to a third party and gives permission for a third party to sign relevant documentation on their behalf. The third party must agree to act for the injured person or claimant by signing the declaration in this form.

Authorising a third party to sign Medicare Compensation Recovery documentation on your behalf means that you will be bound by their actions.

An injured person can revoke this authority verbally or in writing.

An authorised third party can revoke this authority in writing.

Definitions

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

Claimant is the person making a claim for compensation under the *Health and Other Services (Compensation) Act 1995* (the Act) either on their own behalf or on behalf of another person.

Authorised third party is an organisation (such as a law firm) who is being authorised in this form to act on behalf of the injured person or claimant under the Act.

Legal representative is a person who has been appointed by law to act on the injured person's behalf such as an executor, court order, power of attorney.

The *Health and Other Services (Compensation) Act 1995* is available at **legislation.gov.au**

For more information

Go to **servicesaustralia.gov.au/medicarecompensationrecovery** or call 1800 777 653 Monday to Friday, 8:30 am to 5 pm (local time).

Information in your language

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'.

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.

Compensation case or claim reference numbers

1 Compensation case or claim reference numbers (if known)

Medicare

Insurer

Injured person's details

2 Is the injured person listed on a Medicare card?

No ☐

Yes ☐ Provide Medicare card number Ref no.

3 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Second given name

4 Date of birth (DD MM YYYY)

5 Postal address

Postcode

6 Daytime phone number (including area code)

Mobile phone number

Email

7 Date of injury or illness (DD MM YYYY)

If exact date is unknown, write the 1st of the month and year or date of the first treatment. The date of injury must match the one on the case.

8 Is this form being completed on behalf of the injured person?

No ☐ ***Go to 11***

Yes ☐

9 Which of the following best describes the injured person?

Tick one only

Younger than 14 ☐

14 or older and does not have the capacity to act on their own behalf ☐

Deceased ☐

If this claim is being made on behalf of someone **14 or older who does not have the capacity to act on their own behalf or is deceased**, provide supporting documentation (for example, power of attorney, court order, last will and testament, probate).

Claimant's details

10 Claimant 1

What is your relationship to the injured person?

Tick one only

Parent ☐

Guardian ☐

Legal representative ☐

Public trustee ☐

Other ☐ Give details below

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name or business name (if applicable)

First given name

Second given name

Postal address

Postcode

Daytime phone number (including area code)

Mobile phone number

Email

Claimant 2

What is your relationship to the injured person?

Tick one only

Parent ☐

Guardian ☐

Legal representative ☐

Public trustee ☐

Other ☐ Give details below

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name or business name (if applicable)

First given name

Second given name

Postal address

Postcode

Daytime phone number (including area code)

Mobile phone number

Email

Third party's details

11 What is the relationship of the third party to the injured person?

Tick one only

Solicitor ☐

Friend ☐

Relative ☐

Legal representative ☐

12 Authorised third party's case reference (if known)

13 Business name (if applicable)

14 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Authorised third party's family name

First given name

Second given name

15 Postal address

Postcode

16 Daytime phone number (including area code)

Mobile phone number

Email

Privacy notice

17 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, issue notices and manage the compensation claim under the *Health and Other Services (Compensation) Act 1995*. Your personal and sensitive information may be disclosed to the injured person, claimant, legal representative, authorised third party, compensation payer, notifiable person or the Department of Health and Aged Care.

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**

Injured person's or claimant's declaration

18 **I authorise**:

- **the third party (as referenced in the *Third party's details* section) to act on my behalf** in relation to my claim for compensation under the *Health and Other Services (Compensation) Act 1995*. This includes receiving documents from Services Australia, viewing/modifying my record, completing all functions in relation to my claim for compensation and/or signing all relevant documents in relation to my claim for compensation.

I declare that:

- I have read the **Privacy notice** at question 17.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Injured person's or claimant's full name

Injured person's or claimant's signature

On completion, insert digital signature or print and sign.

Date (DD MM YYYY)

Authorised third party's declaration

19 **I declare that**:

- I have read the **Privacy notice** at question 17.
- I undertake to act as an authorised third party for the injured person or claimant.

Authorised third party's full name

Authorised third party's signature

On completion, insert digital signature or print and sign.

Date (DD MM YYYY)

Returning this form

Check that all required questions are answered and the form is signed and dated. Incomplete forms will not be processed. Edits or additions to previously submitted forms will not be accepted.

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.
- fax to 07 3004 5406
- post to
  Services Australia
  Medicare Compensation Recovery
  GPO Box 2436
  BRISBANE QLD 4001

Reset form