Australian Government
Services Australia

medicare

Medicare Compensation Recovery Notice of past benefits request (MO026)

When to use this form

This form is to be completed by either the:

- injured person or claimant (such as a legal representative)
- injured person's or claimant's authorised third party
- compensation payer.

This form is the first step in requesting a notice of past benefits under section 21 of the *Health and Other Services (Compensation) Act 1995*.

When this form is submitted, a Medicare history statement and declaration will be issued to the injured person (or claimant) for completion before a notice of past benefits can be issued.

If you have a valid notice of past benefits and require a new notice of past benefits, you must provide details of extenuating circumstances, by contacting Services Australia.

The notice of past benefits expires 6 months from the date of issue.

If a reimbursement arrangement has been made, do not complete this form. Refer to **Medicare Compensation Recovery Notice of reimbursement arrangement (MO027)** form.

If the injured person is not listed on a Medicare card and has not received any aged care benefits or subsidies in relation to this claim, you are **not required to complete this form** or notify us of this case.

Do not complete this form if the compensation claim relates to a Bulk Payment Agreement, contact the notifiable person.

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 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 either an organisation (such as a law firm) or an individual (such as a friend or relative) who is being authorised in this form to act on behalf of the injured person or claimant under the Act. This also includes a legal representative.

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.

Notifiable person is the person against who the claim is made.

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 Injured person's Medicare card number (if known)

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

Claim details

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 Brief description of the injury or illness

9 Type of compensation being claimed:

Tick one only

- Workers' compensation ☐
- Motor vehicle accident ☐
- Common law ☐
- Public liability ☐
- Other ☐ Give details below

10 Has the injured person made more than one claim for compensation for this same injury or illness?

- No ☐
- Yes ☐ Give details of all other compensation claims below

Other compensation claim 1

Compensation case or claim reference numbers (if known)

Medicare

Insurer

Compensation type

Other compensation claim 2

Compensation case or claim reference numbers (if known)

Medicare

Insurer

Compensation type

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

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

- No ☐ ***Go to 17***
- Yes ☐

12 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 ☐

Claimant's details

13 What is your relationship to the injured person?

Tick one only

- Parent ☐
- Guardian ☐
- Legal representative ☐
- Solicitor ☐
- Public trustee ☐
- Other ☐ Give details below

14 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name or business name (if applicable)

First given name

Second given name

15 Postal address

Postcode

16 Daytime phone number (including area code)

Mobile phone number

Email

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.

17 Is there a solicitor or an authorised third party acting on behalf of the injured person?

No ☐ ***Go to 24***

Yes ☐

18 What is the solicitor's or authorised third party's relationship to the injured person?

Tick one only

Parent ☐

Guardian ☐

Legal representative ☐

Solicitor ☐

Public trustee ☐

Other ☐ Give details below

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).

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

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

21 Contact person's full name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Second given name

22 Postal address

Postcode

23 Daytime phone number (including area code)

Email

Details of compensation payer(s)

24 Compensation payer 1

This party will be liable to pay the charge for recoverable benefits and subsidies.

Compensation payer's case reference

Compensation payer's business name

Australian Business Number (ABN)

Postal address

Postcode

Contact person's full name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Second given name

Contact person's position (for example, claim manager, compensation assessor)

Daytime phone number (including area code)

Email

Compensation payer 1's solicitor or agent (if applicable)

Solicitor's or agent's case reference

Solicitor's or agent's business name

Australian Business Number (ABN)

Postal address

Postcode

Contact person's full name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Second given name

Contact person's position (for example, claim manager, compensation assessor)

Daytime phone number (including area code)

Email

25 Is there more than one compensation payer?

No ☐ ***Go to 27***

Yes ☐ *Go to next question*

26 Compensation payer 2

Compensation payer's case reference

Compensation payer's business name

Australian Business Number (ABN)

Postal address

Postcode

Contact person's full name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Second given name

Contact person's position (for example, claim manager, compensation assessor)

Daytime phone number (including area code)

Email

Compensation payer 2's solicitor or agent (if applicable)

Solicitor's or agent's case reference

Solicitor's or agent's business name

Australian Business Number (ABN)

Postal address

Postcode

Contact person's full name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

Contact person's position (for example, claim manager, compensation assessor)

Daytime phone number (including area code)

Email

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

Privacy notice

27 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**

Declaration

28 **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.

Full name

Title (injured person, claimant, injured person's or claimant's authorised third party or compensation payer)

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.

Please submit and send this form individually for each case.

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