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 or agent 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. If the injured person is **not** listed on a Medicare card and has not received any care costs in relation to this claim, the compensation payer **is not required to complete this form** or notify us of this case.

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.

If a reimbursement arrangement has **not** been made, refer to the **Medicare Compensation Recovery Notice of past benefits request (M0026)** form.

Definitions

Compensation payer is the person who is liable to make a payment of compensation and can include a notifiable person.

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

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.

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

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

Reimbursement arrangement details

2 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 (DD MM YYYY)

Provide the date the reimbursement arrangement was made (DD MM YYYY)

3 Is there a specified liability period that has been determined by an appeal process?

No ☐ *Go to next question*

Yes ☐ Provide the date range

From (DD MM YYYY)

To (DD MM YYYY)

Provide a copy of the appeal decision document.

Injured person's details

4 Medicare card number (if known)

Ref no.

5 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Second given name

6 Date of birth (DD MM YYYY)

7 Postal address

Postcode

8 Daytime phone number (including area code)

Mobile phone number

Email

Claim details

9 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.

10 Brief description of the injury or illness

11 Type of compensation being claimed:

Tick one only

Workers' compensation ☐

Motor vehicle accident ☐

Common law ☐

Public liability ☐

Other ☐ Give details below

Details of compensation payer(s)

12 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

13 Is there more than one compensation payer?

No ☐ ***Go to 15***

Yes ☐ *Go to next question*

14 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.

Payment details

15 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.

Email a remittance advice including insurer's/compensation payer's name and claim number, injured person's name and Medicare card number (if known), compensation case reference, payment amount and date of payment to **medicare.compensation.finance@servicesaustralia.gov.au**

If you are making a payment for multiple claimants, the remittance advice must clearly identify each individual case.

If you do not have a unique account number, request one by emailing the above email address with the following:

- business name, and
- postal address.

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

Privacy notice

16 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

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

17 **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 insurer or compensation payer's solicitor or agent's full name

Compensation payer's insurer or compensation payer's solicitor or agent'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.

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