

medicare

When to use this form

Health professionals, private health insurers and approved billing agents should use this form when an adjustment is required to a previously processed claim that needs to be amended with new or altered information.

Only use this form where you have submitted a Simplified Billing or ECLIPSE claim under Schemes (SC), Agreement (AG), Billing Agent Medicare and private health insurer (MB) or Billing Agent Medicare only (MO) arrangements and where you are submitting claims with the same original claim details.

Complete a separate form for each claim for which adjustments are required.

Adjustments may include changing service details that were included and/or adding services that were omitted during the original assessment. Omitted services must be from the original assessment where they form part of a multi-procedure, such as derived fee services, diagnostic multiple services rule or relative value guide for anaesthetic.

If the payment of an omitted or rejected service does not depend on the assessment of previously submitted services, the service must be resubmitted in a new claim.

This form is an approved form under subsection 20B(2)(a) of the *Health Insurance Act 1973*.

Information for making an adjustment claim for Simplified Billing or ECLIPSE services

We will process your claim and:

- a statement of benefit will be forwarded via secure messaging in a CSV file when the claim is processed
- if the claim results in an underpayment, the benefit will be paid via electronic funds transfer to the private health insurer or approved billing agent
- if the claim results in an overpayment, the statement of benefit will show details of the adjustment and include the amount of overpayment. We will invoice private health insurers and approved billing agents for overpayments
- details of each patient adjustment will be shown on the statement of benefit for the adjustment claim.

For more information

Go to **servicesaustralia.gov.au/simplifiedbilling** or call 1300 130 043 Monday to Friday, 8:30 am to 5 pm, local time.

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.

Applicant's details

1	Tick one of the following options to best identify the applicant. Health professional Private health insurer			
	Approved billing agent			
2	Dr Mr Mrs Miss Ms Mx Other			
	Family name			
	First given name			
	Position held			
	Business phone number (including area code)			
	Fax number (including area code)			
~				
3	Original claim ID			
4	Original date of lodgement (DD MM YYYY)			



Pa	tient's details originally submitted	Hea	alth professional's declaration		
5	Medicare card number		Only complete this section if you are the health professional completing the form.		
6	Patient's full name	10	I declare that:		
			• I am the health professional who performed the services to the patient nominated.		
	Family name		 the information I have provided in this form is complete and correct. 		
	First given name		 I understand that: giving false or misleading information is a serious offence. Your full name 		
	Second given name				
			Your signature		
7	Provider number		<u>E</u> 1		
•			<i>p</i> 0		
8	Reason for adjustment		Date (DD MM YYYY)		
			vate health insurer or approved billing agent claration		
		11	Private health insurer or approved billing agent name		
			Minor ID		
			Adjustment Claim ID Business phone number (including area code)		
		12	I declare that:		
			 I am an authorised representative on behalf of the private health insurer or approved billing agent. 		
			I understand that:		
			• giving false or misleading information is a serious offence. Your full name		
	If you need more space, provide a separate sheet with details.		Your signature		
Privacy notice			<u>E</u> J		
9	The privacy and security of your personal information is important to us, and is protected by law. We collect this		Date (DD MM YYYY)		
	information so we can process and manage your applications and payments, and provide services to you. We only share your		eturning this form		
	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	ар	ealth professionals – forward to the private health insurer or proved billing agent.		
			ivate health insurers and approved billing agents – return is form with the amended and endorsed invoice/accounts by:		
			email to mps.assessing@servicesaustralia.gov.au There may be risks with sending personal information through unsecured networks or email channels.		
			four to (00) 0005 7000		

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Health professional's dealeration

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• fax to (03) 9605 7006.