

# Disaster Health Care Assistance Scheme claim (MS035)

## When to use this form

Use this form to claim out-of-pocket health care expenses that relate to the following:

- **2002 Bali** – Bombings in Bali on 12 October 2002
- **2004 Tsunami** – Indian Ocean tsunami on 26 December 2004
- **2005 London** – Bombings in London on 7 July 2005
- **2005 Bali** – Bombings in Bali on 1 October 2005
- **2006 Dahab, Egypt** – Bombings in Dahab, Egypt on 24 April 2006.

## Important information

To claim for assistance, you **must**:

- be registered with the Disaster Health Care Assistance Scheme
- provide medical evidence from a relevant medical practitioner that the goods or services are for treatment of an injury or injuries resulting from an eligible adverse event
- have already claimed from Medicare, other state or territory government schemes and private travel or health insurance funds.

If you want to claim for assistance with costs that relate to travel expenses, you need to complete the **Disaster Health Care Assistance Scheme motor vehicle or accommodation out-of-pocket travel application (MS042)** form.

To get a copy of this form:

- go to [servicesaustralia.gov.au/forms](http://servicesaustralia.gov.au/forms)
- email [disasterhealthcare@servicesaustralia.gov.au](mailto:disasterhealthcare@servicesaustralia.gov.au)
- call 1800 660 026.

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

## For more information

Go to [servicesaustralia.gov.au/disasterhealthcare](http://servicesaustralia.gov.au/disasterhealthcare) or call 1800 660 026 Monday to Friday, 7:30 am to 5 pm, local time.

## Filling in this form

You can complete this form on your computer using Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader, you can print this form.

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.

## Services covered

### 1 What adverse event are you registered under?

**2002 Bali** – Bombings in Bali on 12 October 2002 ☐

**2004 Tsunami** – Indian Ocean tsunami on 26 December 2004 ☐

**2005 London** – Bombings in London on 7 July 2005 ☐

**2005 Bali** – Bombings in Bali on 1 October 2005 ☐

**2006 Dahab, Egypt** – Bombings in Dahab, Egypt on 24 April 2006 ☐

### 2 Have you provided Services Australia with medical evidence that states the goods or services detailed in this claim are for an injury or injuries caused by the adverse event selected in question 1?

No ☐



Provide evidence from a relevant medical practitioner that the goods or services detailed in this claim are for an injury or injuries caused by an adverse event listed in question 1. If you are not sure, call us on **1800 660 026** to discuss.

Yes ☐



MCA0MS035 2503

## Registered person's details

### 3 Registered person's Medicare card number

Ref no. 

### 4 Registered person's name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other 

Family name

First given name

### 5 Registered person's postal address

  
  
  
 Postcode

### 6 Registered person's preferred contact phone number (including area code)

### 7 Registered person's email

## Claim details

### 8 Out-of-pocket costs are paid for some or all of the following services related to the injury or injuries caused by the adverse event.

Which type of goods and services were received:

Tick all that apply

Hospital ☐ Allied ☐Pharmaceutical ☐ Medical ☐

### 9 Provide details of the goods or services being claimed as well as evidence from your provider that your claim(s) relate to an injury or injuries caused by the adverse event.

#### Goods or service 1

Date of service (DD MM YYYY)	
<input type="text"/>	<input type="text"/>
Description of goods or service	
<input type="text"/>	
Service provided by (for example, Dr A P Jones)	
<input type="text"/>	
Total cost	\$ <input type="text"/>
Costs paid for in full?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Receipt or invoice provided?	No <input type="checkbox"/> Yes <input type="checkbox"/>


## Goods or service 2

Date of service (DD MM YYYY)	
<input type="text"/>	<input type="text"/>
Description of goods or service	
<input type="text"/>	
Service provided by (for example, Dr A P Jones)	
<input type="text"/>	
Total cost	\$ <input type="text"/>
Costs paid for in full?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Receipt or invoice provided?	No <input type="checkbox"/> Yes <input type="checkbox"/>

## Goods or service 3

Date of service (DD MM YYYY)	
<input type="text"/>	<input type="text"/>
Description of goods or service	
<input type="text"/>	
Service provided by (for example, Dr A P Jones)	
<input type="text"/>	
Total cost	\$ <input type="text"/>
Costs paid for in full?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Receipt or invoice provided?	No <input type="checkbox"/> Yes <input type="checkbox"/>

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

 Provide all receipts or invoices for the listed goods or services.

## Private health fund details

For benefits to be paid, make sure you claim from your private health fund or other insurance fund before making this claim. You will need to provide accounts for any assistance you have received from these funds with your claim.

### 10 Are you a member of a private health fund?

No ☐ **Go to 15**Yes ☐


### 11 Name of your private health fund

### 12 Membership number

### 13 Type of cover

Hospital ☐ Ancillary ☐ Both ☐

### 14 Have you already claimed these goods or services from your fund?

No ☐ **Go to 16**Yes ☐  Provide all receipts, invoices or statements for those claims.

- 15 How much have you already been reimbursed for these goods or services?

**Reimbursement 1**

Date of service (DD MM YYYY)	
Description of goods or service	
Benefits paid	\$
Receipt, invoice or statement provided?	No <input type="checkbox"/> Yes <input type="checkbox"/>

**Reimbursement 2**

Date of service (DD MM YYYY)	
Description of goods or service	
Benefits paid	\$
Receipt, invoice or statement provided?	No <input type="checkbox"/> Yes <input type="checkbox"/>

**Reimbursement 3**

Date of service (DD MM YYYY)	
Description of goods or service	
Benefits paid	\$
Receipt, invoice or statement provided?	No <input type="checkbox"/> Yes <input type="checkbox"/>

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



Provide all receipts and invoices from your private health fund or other insurance fund.

- 16 Are any expenses recoverable through any other type of insurance (for example, travel insurance)?

No ☐ **Go to 20**

Yes ☐

- 17 Name of company where policy is held

- 18 Policy number

- 19 How much has been reimbursed from this insurance fund?

\$



Provide all receipts and invoices for those claims.

- 20 Have you tried claiming assistance for these goods or services from any state or territory government or other disaster assistance schemes?

No ☐ You will need to make sure you have claimed from any state or territory government or other disaster assistance schemes for these goods or services before submitting this claim. You will also need to provide proof of evidence of claims for these schemes. If you are not sure, call us on **1800 660 026** to discuss.

Yes ☐



Provide all receipts, invoices, statements and any letters received from your state or territory government or other Disaster Health Care Assistance Scheme.

**Payment details**

Payments will be addressed to the person or provider named in this question.

- 21 Payment for this claim is to be made to the:

**Tick one only**

Registered person ☐ **Go to 23**

Provider of goods or services ☐

- 22 Provider's details

Provider's name

Provider's postal address

Postcode

**Bank account details of person to be paid**

All payments are made through Electronic Funds Transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT deposits.

Payments cannot be made to an account used exclusively for funding from the National Disability Insurance Scheme.

- 23 Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of


## Privacy notice

- 24** 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](https://servicesaustralia.gov.au/privacypolicy)

## Claimant's declaration

The person who received the goods or services

- 25** I hereby claim payment for out-of-pocket expenses incurred as a result of an adverse event covered by the Disaster Health Care Assistance Scheme.

### I declare that:

- I am registered and eligible to receive assistance under the Disaster Health Care Assistance Scheme
- I am the recipient of the goods or services being claimed
- the goods or services being claimed are to treat an injury or injuries caused by one or more adverse events covered by the Disaster Health Care Assistance Scheme
- all other entitlements and benefits (both government and insurance) have been claimed where possible
- all out-of-pocket expenses claimed by me relate to goods or services for which I am entitled to claim payment under the Disaster Health Care Assistance Scheme
- the information I have provided in this form is complete and correct.

### I authorise:

- Services Australia to contact the provider of the goods or services or the originator of any documentation if clarification of details on accounts, receipts or statements is required for payment purposes
- Services Australia to obtain personal information from other agencies and organisations for the purpose of assessing registration and claims.

### I consent to:

- Services Australia using my Medicare card number to validate appropriate payments
- Services Australia checking Medicare payments, Pharmaceutical Benefits Scheme payments and private hospital payments, **or**
- Services Australia undertaking verification related to any other benefit program or assistance provided by the Australian, state or territory governments or by any other non-government organisation, including private health and travel insurers, to which the Disaster Health Care Assistance Scheme may be directly related.

### I understand that:

- benefits are provided under the Disaster Health Care Assistance Scheme as a result of information that I have provided
- giving false or misleading information may result in Services Australia recovering benefits provided by the Disaster Health Care Assistance Scheme
- giving false or misleading information is a serious offence.

Claimant's signature



Date (DD MM YYYY)

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## Provider's declaration

Complete this section if the provider is the person receiving the payment.

**26** I hereby claim payment for out-of-pocket expenses incurred as a result of providing goods or services to treat the injury or injuries of a registered person who was injured as a result of an adverse event covered by the Disaster Health Care Assistance Scheme.

### I declare that:

- I have provided goods or services to a registered person eligible to receive assistance under the Disaster Health Care Assistance Scheme
- the goods or services are treating an injury or injuries caused by an adverse event covered by the Disaster Health Care Assistance Scheme
- all other entitlements and benefits (both government and insurance) have been claimed where possible
- all of out-of-pocket expenses claimed by me relate to goods or services for which I am entitled to claim payment under the Disaster Health Care Assistance Scheme
- the information I have provided in this form is complete and correct.

### I authorise:

- Services Australia to contact me about the goods or services or the originator of any documentation if clarification of details on accounts, receipts or statements is required for payment purposes.

### I understand that:

- benefits are provided under the Disaster Health Care Assistance Scheme as a result of information that I have provided
- giving false or misleading information may result in Services Australia recovering benefits provided by the Disaster Health Care Assistance Scheme
- giving false or misleading information is a serious offence.

Provider's signature



Date (DD MM YYYY)

Services Australia will keep all documents used to support this claim.

## Returning this form

Check that you have answered all the questions you need to answer and the form is signed and dated.

Return this form and any supporting documents, including copies of any Medicare claim documents, claimant accounts, receipts, travel or private health insurance documentation:

- by **email** to  
**disasterhealthcare@servicesaustralia.gov.au**  
There may be risks with sending personal information through unsecured networks or email channels.
- by post to  
Services Australia  
Disaster Health Care Assistance Scheme  
PO Box 9822  
In your capital city
- in person at one of our service centres.