

## LODGEMENT ADVICE

Electronic Claim for assessment by Services Australia

**THIS FORM CANNOT BE USED TO MAKE A CLAIM FOR MEDICARE PAYMENTS.  
THIS CLAIM HAS ALREADY BEEN SUBMITTED TO MEDICARE ON YOUR BEHALF.**

**Location ID:**

**Claim Reference:  
Servicing Location:**

### Patient Details

Medicare Card No:

IRN

First Name and Surname:

Date of Birth:

### Claimant Details

Medicare Card No:

IRN

First Name and Surname:

Date of Birth:

Telephone No :

Address:

This claim has been: **REFERRED TO SERVICES AUSTRALIA/STORED FOR LATER TRANSMISSION**

Servicing Provider Name:

Payee Provider:

Servicing Provider No:

Payee Provider No:

Requesting/Referring

ACRF:

Provider Name:

Requesting/Referring

Provider No:

Date of Request/Referral:

Period of Referral:

Date of Service	Item No	Description of Service	Charge	Patient Contribution
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**Total:**

### Payment Details:

- This account is fully paid: YES/NO
- The Medicare benefit will be paid:
  - To the account as displayed below or
  - If your bank account details are stored with Medicare your payment will be made by EFT, if not, your Medicare benefit will not be paid. Once you have provided Medicare with your bank account details, your payment will be released.
- If required, correspondence regarding this claim will be directed to the: ABOVE ADDRESS/ADDRESS HELD BY MEDICARE.  
This includes, if applicable, any Pay Doctor via Claimant (PDVC) cheques for the service provider. It is the responsibility of the claimant to forward the PDVC cheque to the service provider.

### Claimant Declaration

I have paid for or am liable to pay the expenses for these services and these services are not excluded under the *Health Insurance Act 1973* (i.e. are not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with employment) and/or *Dental Benefits Act 2008*. To the best of my knowledge and belief all the information disclosed in the lodging of this claim is true and accurate. I authorise the medical practice to electronically transmit my claim for benefits to Services Australia on my behalf. I also authorise Services Australia to contact the referring provider or the provider of the services if clarification of details on the account and/or receipt is required for assessment or auditing purposes.

For this claim, I have consented to this practice sending to and receiving from Services Australia, the following information for verification:

- The patient's enrolment information including the patient's Medicare card and issue number;
- The patient's first name and individual reference number;
- The claimant's postcode information provided it matches my records; and
- The benefit amount for each service in this claim.

**Privacy Notice:** Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by Services Australia for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the agency or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which Services Australia will manage your personal information, including our privacy policy at [servicesaustralia.gov.au/privacy](http://servicesaustralia.gov.au/privacy) or by requesting a copy from the agency.

I authorise the payment of my benefits for this claim to be paid directly into the following bank or financial institution account:

BSB Number:	
Account Number:	
Account Name:	