

There are 2 ways to apply to IPTAAS

Apply online at iptaas.enable.health.nsw.gov.au **OR** complete this form.

When using this form

Patients may be eligible for an accommodation facility to invoice IPTAAS directly for accommodation costs.

This form should be used if:

- the patient and/or escort is staying in the accommodation facility for three or more consecutive nights
- the patient is applying to bulk bill accommodation costs.

When using this form

There are instructional boxes under each section to help when filling in this form.

There are also sections of the form that will need to be completed by other people.

If the patient is medically required to fly to their appointment or treatment, the referring health professional, specialist, health service or authorised representative must call and obtain an air approval code before they fly.

When the patient leaves the accommodation facility, they need to provide a **Form 2 Additional travel and accommodation claims**. That form should be submitted to IPTAAS along with:

- invoices for travel and non-bulk billed accommodation
- invoice for bulk billed accommodation.

Commonly used terms in this form

Referring health professional

This is the person who refers the patient for an appointment or treatment. This is usually a GP or can be a dentist, midwife, optometrist, or a visiting medical officer.

Specialist or health service

This is the person or service who treats the patient for their health condition. An example is a heart specialist who is also known as a cardiologist.

Authorised representative

This is a person who can confirm a patient's appointment or treatment and is employed by the same service as the patient's health professional, specialist or health service. This can be medical staff, administrative staff, nursing staff and social workers.

Escort

This is a person who travels and/or stays with a patient and provides support during their appointment or treatment. This is usually a spouse, carer, friend or parent.

Part A. Eligibility details (to be filled in by the patient, parent, guardian, escort, authorised contact or third party organisation)

Patients receiving financial assistance for travel and accommodation from other services are not eligible for IPTAAS. If receiving other assistance, contact the IPTAAS team to confirm eligibility.

1. Has the patient received, or is eligible for financial assistance for travel and accommodation from the following, not including IPTAAS (select which apply):

- | | |
|--|--|
| ☐ Another Australian federal, state or territory government travel scheme | ☐ Department of Veterans' Affairs (DVA) |
| ☐ Workers compensation | ☐ Motor vehicle insurance |

2. Is the patient and/or escort staying in the accommodation facility 3 or more nights? ☐ Yes ☐ No **The patient is not eligible to bulk bill accommodation.**

Name of accommodation facility:

Part B. Patient details (to be filled in by the patient, parent, guardian, escort, authorised contact or third party organisation)

3. Patient name	Title	First name	Middle name	Surname

4. Patient date of birth (dd/mm/yyyy)

5. Patient gender ☐ Male ☐ Female ☐ Non-binary ☐ Other

6. Patient Medicare card number Individual Reference Number (number to the left of the name on the card)

7. Patient contact details

Email	Phone number inc. area code	Mobile

What is the preferred contact method? ☐ Post ☐ Email ☐ Phone ☐ Mobile

8. Patient residential address State Postcode

9. Patient postal address (if different to residential) State Postcode

10. Does the patient identify as Aboriginal and/or Torres Strait Islander? ☐ No ☐ Yes

11. Preferred language (if not English) ☐ Arabic ☐ Cantonese ☐ Filipino/Tagalog ☐ Greek ☐ Hindi ☐ Italian ☐ Mandarin ☐ Punjabi ☐ Spanish ☐ Vietnamese ☐ Other

12. Patient authorised contact Name Relationship to patient Phone number inc. area code Mobile

(optional)

Part C. Type of treatment (to be filled in by the patient, specialist, health service or authorised representative)

If you are unsure about the details asked in this part the patient's specialist, health service or authorised representative will be able to help.

13. What type of treatment did the patient travel for? (Select the treatment and tick any applicable information.)

☐ **Specialist treatment**

☐ The patient's treatment was part of a non-commercial clinical trial.

☐ The patient received a reimbursement for travel and accommodation for the clinical trial.

☐ The patient's travel was for health screening (example mammogram).

☐ **Specialty health clinic**

☐ **Dental**

☐ The patient has a cleft palate.

☐ The patient had surgery under general anaesthesia.

☐ **Prosthetic/Orthotic**

☐ The patient travelled to a public hospital or public clinic.

☐ **High risk foot services**

☐ **Oral health clinic**

☐ The patient used a voucher to attend a private provider. (attach a copy of the voucher).

☐ **Palliative care**

Part D. Health professional details (to be filled in by the patient, parent, guardian, escort, or authorised contact)

This section should be completed by the patient to share the details of the health professional who made the referral to the specialist or health service.
A health professional is usually a General Practitioner (GP) or can be a dentist, midwife, optometrist, or a visiting medical officer.

14. Referring health professional's details Full name Phone number inc. area code

15. Who is the patient being referred to? Name of specialist or health service referred to Location Referral date

16. Is the specialist or health service the nearest to the patient's residence? ☐ Yes. ☐ No. If no, give details below.

What was the reason for not attending the nearest specialist or health service?

Part E. Treatment details (to be filled in by the patient, parent, guardian, escort, or authorised contact)

17. Treatment details	Name of specialist, specialty health clinic, dentist, prosthetist/orthotist, high risk foot service, oral health clinic or clinical trial	Phone number inc. area code	
	Specialist Medicare provider number		
	Treatment address	State	Postcode

18. Appointment details Appointment start date (dd/mm/yyyy) End date (dd/mm/yyyy)

Part F. Escort details (to be filled in by the patient, parent, guardian, escort, or authorised contact)

19. Was the patient accompanied by an escort during travel or accommodation? ☐ No. ► **Go to Part G.** ☐ Yes. ► Give details below.

Escort's full name

Part G. Payment details (to be filled in by the patient, parent, guardian, escort, or authorised contact)

20. Details of nominated bank account for patient travel subsidy:

Account name	BSB number	Account number

Part H. Accommodation facility declaration (to be filled in by the accommodation facility staff)

21. Accommodation facility declaration

☐

I declare that:

- Our accommodation facility is registered with IPTAAS as a third party organisation.
- The information I have provided in this application is correct and the documents provided are genuine.
- The patient and/or their escort have requested to bulk bill their accommodation costs, and they have authorised us to submit this application on their behalf.
- We have explained the requirements of bulk billing to the patient and/or their escort and will ensure they provide an **Form 2 Additional Travel and Accommodation claims form** when leaving the facility.
- We will keep patient information secure and not provide any patient information to parties who are not directly involved in bulk billing accommodation.
- The patient agrees and confirms that the accommodation provider is authorised to provide the personal details presented and that the patient consents to their information being checked with the document issuer or official record holder via third party systems for the purpose of confirming my identity.

☐

I understand that:

- NSW Health may make relevant enquiries to assess this application and make sure we receive the correct subsidy.
- We should get a bulk billing approval before the patient leaves the facility. If we fail to do so the accommodating costs may not be payable by IPTAAS.
- IPTAAS is not a full reimbursement scheme and costs outside the applicable accommodation subsidy are the patient's responsibility.
- Applications older than 12 months may not be approved.
- Giving false or misleading information is an offence.

By signing this document, I agree with the above declaration and privacy statement.

Name of person completing this section:

Sign by typing in your name

Date (dd/mm/yyyy)

Part I. Declaration and privacy (to be filled in by the patient, parent, guardian, escort, or authorised contact)

The information contained in this application is protected by law from unauthorised access and misuse. The information will only be accessed by health service staff directly involved in providing services to the applicant, or with other lawful excuse. You can view our privacy statement on our website. The application may be audited to confirm the evidence and the information listed on the form. Patient's may be asked to provide evidence in the form of a Medicare benefit statement, a medical certificate or hospital discharge papers, an appointment schedule or written confirmation from the specialist or health service.

22. Patient declaration

☐

I declare that:

- The information I have provided in this form is complete and correct and the documents provided are genuine.
- If applicable, I am authorised to complete this application on behalf of the patient.

☐

I understand that:

- NSW Health may make relevant enquiries to assess this application and make sure I receive the correct subsidy.
- I am required to submit a **Form 2 Additional travel and accommodation claims form** when leaving the facility.
- I am required to advise IPTAAS as soon as possible for any changes to bookings. I will be responsible for booking and/or paying for missed travel and/or accommodation unless changes are related to medical reasons and I have a certificate to support the changes.
- Giving false or misleading information is an offence.
- **I confirm** that I am authorised to provide the personal details presented and I consent to my information being checked with the document issuer or official record holder via third party systems for the purpose of confirming my identity.

By signing this document, I agree with the above declaration and privacy statement. Name of person completing this form:

Sign by typing in your name

Date (dd/mm/yyyy)

Submitting this form

Check that all required questions are answered and that the form is signed and dated. Return this form and supporting documentation to your local IPTAAS office:

By post:

Hunter New England – Tamworth

Post: Locked Bag 9783, Tamworth NEMSC NSW 2348

Email: HNELHD-IPTAAS@health.nsw.gov.au

Fax: (02) 4924 5767

For all other areas

Post: Locked Bag 3005, Sydney Markets NSW 2129

Email: IPTAAS@health.nsw.gov.au

Please ensure forms submitted by post are addressed to IPTAAS.

Far West – Broken Hill

Post: PO Box 457, Broken Hill NSW 2880

Email: FWLHD-IPTAAS@health.nsw.gov.au

Fax: (08) 8080 1695

In person

Tamworth Hospital, Broken Hill Hospital or Port Macquarie Community Health