

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

There are instructional boxes under each section to help fill this form. There are also sections of the form that will need to be completed by other people:

- **Part E:** 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. This code will ensure they are paid at the correct rate.
- **Part G:** If the patient needs to stay 2 or more nights before or after the appointment/treatment dates, the specialist or health service must complete this section.

If you need help, call our team on **1800 478 227** or send us an email to iptaas@health.nsw.gov.au

All claims must be submitted within 12 months of the patient's discharge or appointment end date.

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

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 if any apply):

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

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

2. Patient name

Title First name Middle name Surname

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

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

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

6. Patient contact details

Phone Mobile Email

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

7. Patient residential address State Postcode

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

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

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

11. Patient authorised contact (optional)

Full name Relationship to patient Phone number inc. area code Mobile

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

12. 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 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.

13. Referring health professional’s details

Full name

14. Who is the patient being referred to?

Name of specialist or health service referred to

Location

Referral date

14.1 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. Air travel approval code (to be provided by the health professional, specialist or authorised representative)

The referring health professional, specialist, or authorised representative must call **1800 478 227** to obtain an air approval code, failing to do so may affect the patient’s travel subsidy.

15. What is the air travel approval code?

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

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

Part G. Travel and accommodation details (to be filled in by the patient, specialist, health service or authorised representative)

16. Did someone travel or stay with the patient? (This may also be referred to as an escort, including a spouse, carer, partner or parent.)

☐ No

☐ Yes. If yes, give details.

Escort's full name

Travel mode - Private vehicle - PV - Public transport - PT - Commercial air - AIR - Community transport - CT - Emergency transport - ET - Taxi - TX	People travelling: - Patient only - P - Escort only - E - Patient and escort - PE	Trip type: - One way - O - Return - R	Accommodation type: - Private accommodation (staying with family, friends or in AirBNB) - Paid accommodation - Bulk Billing (accommodation that is to be paid to a third party organisation)
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17. Travel dates (provide dates in dd/mm/yyyy format)

Travel dates	Travel mode	People travelling	Trip type	Address	Appointment date	Hospitalisation dates (if applicable)	Accommodation dates (if applicable)	Accommodation type
Travel 1 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 2 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 3 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 4 Start End				From To	Start End	Admission Discharge	Check in Check out	

Attach receipts for accommodation, air, train, bus, or taxi travel, including Uber. Petrol receipts do not need to be provided. Receipts are not needed for stays in a private home. More trips to claim? Use Form 2 Additional travel and accommodation claims to submit additional trips. This form can be found on the IPTAAS website.

18. Did the patient need to stay before or after the appointment or hospitalisation dates?

- ☐ No
- ☐ Yes. Give details.

number of nights before and/or

nights after

If the patient stayed more than 2 nights before or after their appointment or hospitalisation dates, the specialist or health service must sign the declaration below.

19. Specialist or health service declaration

☐ **I confirm** the information in part G is correct including appointment, hospitalisation, and accommodation dates.

☐ **I understand** that giving false or misleading information is an offence.

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

Position

Sign by typing in your name

Date (dd/mm/yyyy)

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

Provide bank details for subsidy payment. If the subsidy is to be paid to a TPO, provide these details in question 21.

20. Details of nominated bank account

Account name

BSB number

Account number

21. Do you want to allocate any part of the payment to a TPO? ☐ Yes ☐ No.

What part of the payment do you want to be paid to the TPO?

☐ Travel ☐ Accommodation ☐ Both ☐ None

Third party organisation details

Name

Phone number inc. area code

ABN

Supplier number (if known)

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 **AND** 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 may be audited and I am required to keep evidence to prove I attended my appointment for two years. 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.