

**When to use this form**

You may be eligible for your accommodation facility to invoice IPTAAS directly for your accommodation costs.

You should use this form if:

- you are staying in the accommodation facility for three or more consecutive nights
- you are applying to bulk your accommodation costs

**What else you may need to provide**

If your accommodation is bulk billed you will need to provide additional documentation when you leave the accommodation facility. You will need to provide **Form 2. Travel and accommodation supplement**.

You may also need to provide:

- invoices for travel and non-bulk billed accommodation costs
- evidence that you have attended your appointment

**Air travel**

If you need to travel by commercial air, you should get an air approval. Your practitioner or their authorised representative must contact IPTAAS to get an air approval. You will only get an air approval if you meet the air approval criteria.

**Filling in this form**

- please use black or blue pen
- print in BLOCK LETTERS
- mark boxes like this  with a ✓ or X
- where you see a box like this  **Go to question...** skip to the question number shown. You do not need to answer the questions in between.

**Submitting your form**

Check that all required questions are answered and that the form is signed and dated.

You can return this form to your accommodation facility who will submit it to your local IPTAAS office by email.

**Hunter New England – Tamworth**

HNELHD-IPTAAS@health.nsw.gov.au

**Northern NSW, Mid North Coast – Port Macquarie**

MNCLHD-TFH-IPTAAS@health.nsw.gov.au

**Far West – Broken Hill**

FWLHD-IPTAAS@health.nsw.gov.au

**All other**

IPTAAS@health.nsw.gov.au

**For more information**

Go to our website [www.iptaas.health.nsw.gov.au](http://www.iptaas.health.nsw.gov.au) or call us on **1800 IPTAAS (1800 478 227)**.

**Part A. Eligibility details**

Please read before answering question 1.

Patients receiving financial assistance for travel and accommodation from other services are not eligible for IPTAAS. If you are receiving assistance from another government or third party service do not complete this form.

**1. Have you received, or are you eligible for financial assistance for travel and accommodation from**

An Australian federal, state or territory government travel scheme, other than IPTAAS?

No  Yes

Department of veterans' affairs?

No  Yes

Workers compensation?

No  Yes

Motor vehicle insurance?

No  Yes

**2. Are you staying in the accommodation facility three or more nights?**

No  **You are not eligible to bulk bill your accommodation.**

Yes

**Part B. Patient details**

**3. Patient ID (if known)**

**4. Your name**

Title	Given name	Middle name	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**5. Your date of birth**

**6. Your gender**

Male  Female  Other

**7. Your Medicare card number**

<input type="text"/>	Line no. <input type="text"/>							
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**8. Do you have a concession card issued by Centrelink or DVA?**

No **Go to question 9**

Yes Give details Concession card number  Concession card expiry date

**9. Your residential address**

<input type="text"/>	
State	Postcode

**10. Your postal address**

(if different to residential)

<input type="text"/>	
State	Postcode

**11. Your contact details** Email  Phone number  Mobile number

What is your preferred contact method?  Post  Email  Phone  Mobile

**12. Are you of Aboriginal or Torres Strait Islander Australian descent?**  No  Yes

**13. Your authorised contact** (optional) Name  Relationship to you

Phone number  Mobile number

## Part C. Referral details

Please read before completing Part C. Referral details.

**Part C: Referral details** is only required if this is the first time you have applied for assistance from IPTAAS to travel to this practitioner or health service, or you have not submitted a referral to this practitioner or health service in the last two years.  
If required, **Part C: Referral details** is to be completed by your referring practitioner or their authorised representative.

**14. Referring practitioner details** Full name  Phone number

**15. Treatment details** Name of practitioner or health service you referred the patient to

Treatment location  Type of treatment referred for

**16. Is the practitioner or health service the nearest to the patient's residence?**  
 Yes **Go to question 17**  No Give details below  
 Why was the patient not referred to the nearest practitioner or health service?

**17. Referring practitioner declaration (to be completed by the referring practitioner or their authorised representative)**

Name  Position

**I declare that:**

- the information provided in Part C of this form is complete and correct

Signature

**I understand that:**

- giving false or misleading information is an offence

Date

D D/M M/Y Y Y Y

## Part D. Treatment details

**18. What type of treatment did you travel for?** (Select **one** and answer applicable questions)

**Specialist**

- Was your treatment part of a clinical trial?  No  Yes  
 Was your travel for health screening?  No  Yes

**Allied Health**

**Dental**

- Do you have a cleft palate?  No  Yes  
 Did you have surgery under general anesthesia?  No  Yes

**Prosthetic/Orthotic**

- Did you travel to a public hospital or public clinic?  No  Yes

**19. Treatment details** Name of specialist, allied health clinic, dentist or prosthetist/orthotist  Phone number

Medicare provider number (not applicable to allied health or prosthetic/orthotic treatment)

OPTIONAL: AHPRA registration number (if known) (not applicable to allied health or prosthetic/orthotic treatment)

Treatment address

State  Postcode

**20. Appointment details**

Start date

D D/M M/Y Y Y Y

End date (if different to start)

D D/M M/Y Y Y Y

## Part E. Accommodation details

### 21. Name of accommodation facility

Accommodation start date

### 22. Were you accompanied by an escort during travel or accommodation?

No **Go to question 24**

Yes Give details Your escort's full name

### 23. Does your escort have a concession card issued by Centrelink or DVA?

No **Go to question 24**

Yes Give details

Your escort's concession card number

Your escort's concession card expiry date

## Part F. Accommodation facility declaration

### 24. Accommodation facility declaration (to be completed by the accommodation facility staff)

#### I declare that:

- Our accommodation facility is registered with IPTAAS as a third party organisation
- 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 **Form 2. Travel and accommodation supplement** 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.

#### I understand that:

- NSW Health may make relevant enquiries to assess this application and make sure we receive the correct subsidy
- We should get an approval before the patient leaves the facility. If we fail to do so the accommodation cost 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.

Name

Signature

Date

## Part G. Patient declaration and privacy

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.

### 25. Patient declaration (to be completed by you or your parent, guardian, escort or authorised contact)

#### 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 the requirements of bulk billing and authorise the accommodation facility to submit this application on my behalf.

#### 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 provide **Form 2. Travel and accommodation supplement** when leaving the facility
- I am responsible for accommodation costs that are not payable by IPTAAS
- Giving false or misleading information is an offence

Your name

Your signature

Date