Australian Government
Services Australia

medicare

Medicare Claim (MS014)

When to use this form: Only use this form when claiming by mail for paid and unpaid accounts.

Staple the **original** itemised accounts **and** receipts to this form.

Returning your form: Send the completed form and original accounts and receipts to: **Services Australia, Medicare, GPO Box 9822** in your capital city.

Patient's details – The patient is the person who received the medical and/or dental service.

1 Patient's Medicare card number ☐☐☐☐ – ☐☐☐☐☐ – ☐ Ref no. ☐

Claimant's details – The claimant is the person who paid for, or is likely to pay for, the medical and/or dental expense(s). The Medicare benefit(s) will be paid to this person.

2 Is the claimant also the patient?

No ☐ Claimant's Medicare card number ☐☐☐☐ – ☐☐☐☐☐ – ☐ Ref no. ☐

Yes ☐ ***Go to 7***

3 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

4 Date of birth / /

5 Gender Male ☐ Female ☐

6 Business name – for non-compensation claims where the claimant is an organisation or business (for example a nursing home) that has incurred the expense(s) on behalf of the patient
OR executor/administrator name

7 Postal address – Do you want to use the address you have recorded with us?

No/unsure ☐ Provide address

Postcode

Yes ☐ ***Go to 9***

8 Do you want this recorded as your permanent postal address for everyone on your Medicare card? No ☐ Yes ☐

9 Email (optional)

10 Daytime phone number ( )

Service details – The medical service(s) you are claiming benefit for.

11

Ref no.	Patient's first given name	Services provided by (for example Dr A P Jones)	Account paid in full?
			No ☐ Yes ☐
			No ☐ Yes ☐
			No ☐ Yes ☐

12 Was the patient an in-patient of a hospital or approved day facility?

No ☐

Yes ☐ Date of admission / / Date of discharge / /

Bank account details – **Important** Medicare benefits are only made through Electronic Funds Transfer (EFT)

13 Have you previously supplied your bank account details? No ☐ Yes ☐ ***Go to 15***

14 To supply or update your bank account details, please provide the following information. These details will be used for future payments.

Medicare benefits **cannot** be paid via electronic funds transfer (EFT) if the nominated account has restrictions on EFT deposits.

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

15 If you want a statement of benefit posted, please tick this box: ☐

If your claim includes in-hospital services, we will automatically issue a statement of benefit to you.

Medicare Safety Net

The Medicare Safety Net provides families and individuals with financial assistance for high out-of-pocket costs for out-of-hospital Medicare Benefits Schedule services. For information or to register, go to **servicesaustralia.gov.au/safetynet** or call **132 011**.
Call charges may apply.

Claimant's declaration

16 I hereby claim benefit(s) for the professional service(s) to which this claim relates and I declare that:

- I have paid for, or am liable to pay, the expenses for these services
- I am the executor or administrator acting on behalf of the deceased claimant's estate (if applicable)
- the services were not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with the patient's employment
- the services were not provided by or on behalf of the Australian Government, a state, territory or a local governing body or an authority established by a law of the Australian Government, a state or territory
- I have not claimed for dental expenses through private health insurance, **and**
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Claimant's signature On completion, print and sign by hand.

Date / /

Privacy notice

The privacy and security of your personal information is important to us, and is protected by law. We need to 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/privacy**

Australian Organ Donor Register *(optional)*

1 Your Medicare card number – – Ref no.

2 Your details

Family name

First given name

Permanent postal address

Postcode

This address will be used to update the Medicare record for everyone on your Medicare card.

Date of birth / / Gender Male ☐ Female ☐

3 I **wish to register my consent** to donate the following organs and/or tissue for transplantation, in the event of my death. *Tick **'All'** or as many as apply*

All ☐ Bone tissue ☐ Eye tissue ☐ Heart ☐
Heart valves ☐ Kidneys ☐ Liver ☐
Lungs ☐ Pancreas ☐ Skin tissue ☐

4 I wish to register my decision **not to be** an organ and/or tissue donor ☐

5 **Organ donor declaration**

I declare that:

- I give permission for the details I have provided to be actioned on the Australian Organ Donor Register.
- I have discussed this decision with my family, partner or friend.
- I am aware that I can change my donation decision details at any time.
- I have read and understood the Privacy notice contained in this form.

Your signature On completion, print and sign by hand.

Date / /

For more information
Go to **servicesaustralia.gov.au/organdonor** or call the Australian Organ Donor Register on **1800 777 203**.
Call charges may apply.