NSW Health

Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)
Form 1. Travel and Accommodation Claims

There are two 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 when filling in this form.
There are also sections of the form that will need to be completed by other people:

- **Part D:** if the patient is medically required to fly to their appointment or treatment, the referring health professional, medical practitioner, health service or authorised representative must call and obtain an air approval code before they fly. This will ensure they are paid at the correct rate.
- **Part F:** If the patient needs to stay two or more nights before or after the appointment/ treatment dates, the medical practitioner or health service must complete this section.

If you need help, call our team on **1800 478 227** or send 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.

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.

Medical practitioner 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, medical practitioner 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, 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 are they 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

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

2. **Patient name** Title | Given name | Middle name | Surname

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

4. **Patient gender** ◯ Male ◯ Female ◯ Non-binary ◯ Prefer to self-describe Self-describe:

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

6. **Patient residential address** State Postcode

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

8. **Patient contact details** Email | Area code | Phone number | Mobile number

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

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) Name | Relationship to patient | Area code | Phone number | Mobile number

Part C. 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 medical practitioner or health service.
A health professional is usually a General Practitioner (GP) or can be a dentist, midwife, optometrist, or a visiting medical officer.

12. Referring health professional's details Full name | Area code | Phone number

13. Who is the patient being referred to? Name of medical practitioner or health service referred to | Location

13.1 Is the practitioner 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 practitioner or health service?

Part D. Air travel approval code (To be provided by the health professional, medical practitioner or their authorised representative)

If the patient is medically required to travel by commercial air, the practitioner or authorised representative is to call **1800 478 227** to obtain an air approval code prior to flying.
If this is not obtained claims will be paid at the private car rate.

14. What is the air travel approval code? LHI PRE-APPROVAL

Part E. Treatment details (To be filled in by the patient, medical practitioner, health service or their authorised representative)

If you are unsure about the details asked in question 15 the patient's practitioner's or health service or authorised representative will be able to help.

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

- ☐ **Specialist**
  - ☐ 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).
- ☐ **Allied Health**
- ☐ **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.
- ☐ **Palliative Care**

Treatment details

Name of specialist, allied health clinic, dentist, prosthetist/orthotist, high risk foot service, oral health clinic or clinical trial | Area code | Phone number

Medicare provider number (only applicable for a specialist)

Treatment address | State | Postcode

Part F. Travel and accommodation details (To be filled in by the patient, medical practitioner, health service or their authorised representative)

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

◯ No ◯ Yes. If yes, give details. The escort's full name

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

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	

Provide any receipts for air, train, or taxi travel (including ride sharing such as Uber). Petrol receipts do not need to be provided. Receipts are not needed for stays in a private home.
Do you have more trips to claim? Use form 2 Additional Travel and Accommodation Claims to submit additional trips. This 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**

The medical practitioner or health service must sign the declaration below if the patient stayed more than two nights before or after their appointment or hospitalisation dates listed on question 17. The application may be audited to confirm the evidence and information listed on the form. Evidence can include a Medicare benefit statement, a medical certificate or hospital discharge papers, an appointment schedule or written confirmation from the practitioner or health service.

19. Medical practitioner or health service declaration

☐ **I confirm** the information in part F 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 G. Payment details (To be filled in by the patient, parent, guardian, escort, or authorised contact)

Please provide the bank details where the subsidy is to be paid. If the subsidy is to be paid direct to a third party organisation, please provide their details in question 21.

20. Details of nominated bank account

Account name

BSB number

Account number

21. What part of the subsidy is to be paid to the third party organisation?

◯ Travel ◯ Accommodation ◯ Both ◯ None

Third party organisation details

Name

Area code

Phone number

ABN

Supplier number (if known)

Part H. 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.

22. Patient declaration (to be completed by the patient, 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 **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 if my practitioner or health service did not complete question 19 of this form, I am required to keep evidence to prove I attended my appointment for two years. 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 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. You can submit this form and supporting documentation to your local IPTAAS office by email, post, fax, or face to face in some locations. Please ensure forms submitted by post are addressed to IPTAAS.

Hunter New England – Tamworth

Call: 1800 478 227 option 1 – Office operating hours Monday - Friday 9am - 4.30pm
Post: Locked Bag 9783, Tamworth NEMSC NSW 2348
Email: HNELHD-IPTAAS@health.nsw.gov.au
Fax: (02) 4924 5767
Location: Tamworth Hospital

Northern NSW, Mid North Coast – Port Macquarie

Call: 1800 478 227 option 2 – Office operating hours Monday - Friday 9am - 4.30pm
Post: PO Box 126, Port Macquarie NSW 2444
Email: MNCLHD-TFH-IPTAAS@health.nsw.gov.au
Fax: (02) 5524 2996
Location: Port Macquarie Community Health, Morton Street, Port Macquarie

Far West – Broken Hill

Call: 1800 478 227 option 3 – Office operating hours Monday - Friday 9am - 4.00pm
Post: PO Box 457, Broken Hill NSW 2880
Email: FWLHD-IPTAAS@health.nsw.gov.au
Fax: (08) 8080 1695
Location: Broken Hill Hospital

For all other areas, please send your completed application by post or email.

Call: 1800 478 227 option 4 – Office operating hours, Monday - Friday 9am - 5pm
Post: Locked Bag 3005, Sydney Markets NSW 2129
Email: IPTAAS@health.nsw.gov.au
Location: Over the counter assistance is also available in Dubbo at the Dubbo Base Hospital