NSW Health

Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)

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 C:** the patients referring health professional will need to complete this section. Each time the patient sees a different medical practitioner or health service, this form with part C needs to be completed again.
- **Part D:** if the patient is medically required to fly to their appointment or treatment the referring health professional, medical practitioner, health serivce 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 patients referring health professional, medical practitioner or health service.
This can be medical staff, administrative staff, nursing staff and social workers.

Escort

This is the person who travels with the patient to their appointment or treatment. This is usually a spouse, carer, friend or parent.

Part A. Eligibility details

Patients receiving financial assistance for travel and accommodation from other services are not eligible for IPTAAS.

1. **Has the patient received, or are they eligible for financial assistance for travel and accommodation from (these should not include IPTAAS)**

☐ No ☐ Yes Another Australian federal, state or territory government travel scheme?
☐ No ☐ Yes Department of Veterans' affairs (DVA)?
☐ No ☐ Yes Workers compensation?
☐ No ☐ Yes Motor vehicle insurance?

Part B. Patient details

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

3. **Patient date of birth** D D/M M/Y Y Y Y

4. **Patient gender** ☐ Male ☐ Female ☐ Prefer not to say

5. **Patient Medicare card number** ☐☐☐☐ ☐☐☐☐☐ ☐ Line no. ☐

6. **Does the patient have a concession card issued by Centrelink or DVA?**

☐ Centrelink ☐ DVA ☐ No

7. **Patient residential address** State Postcode

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

9. **Patient contact details** Email | Phone number ( ) | Mobile number

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

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

11. **Patient authorised contact** (optional) Name | Relationship to patient | Phone number ( ) | Mobile number

Part C. Referral details

This section should be completed by the patient's referring health professional or their authorised representative. A health professional is usually a general practitioner (GP) or can be a dentist, midwife, optometrist or a visiting medical officer.
The patient's health professional should only complete this section:
-If it is the first time applying to IPTAAS **OR**
-If it has been more than two years since they completed this section **OR**
-The patient has been referred to more than one practitioner or health service (each one will need a separate form)

12. **Referring health professionals details** Full name | Phone number ( )

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

13.1 Is the practitioner or health service the nearest to the patient's residence? ☐ Yes ➔ ***Go to question 14*** ☐ No ➔ Give details below

Why was the patient not referred to the nearest practitioner or health service?

14. **Health professionals declaration (to be completed by the health professional or their authorised representative)**

Name | Position

I declare that:
- the information provided in Part C of this form is complete and correct

I understand that:
- giving false or misleading information is an offence

Signature | Date D D/M M/Y Y Y Y

Part D. Air approval code

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.

15. **What is the air approval code?**

Part E. Treatment details

If you are unsure about the details asked in question 16 the patients practitioner's/health service or authorised representative will be able to help.

16. **What type of treatment did the patient travel for?** (Select one and answer applicable questions)

☐ **Specialist**
☐ **Allied Health**
☐ **Dental**
☐ **Prosthetic/Orthotic**
☐ **High Risk Foot Services**
☐ **Oral Health Clinic**

Was the patient's treatment part of a non-commercial clinical trial? ☐ No ☐ Yes

Does the patient have a cleft palate? ☐ No ☐ Yes

Did the patient travel to a public hospital or public clinic? ☐ No ☐ Yes

Was the patient receiving palliative care? ☐ No ☐ Yes

Did the patient receive a reimbursement for travel and accommodation for the clinical trial? ☐ No ☐ Yes

Was the patient's travel for health screening? ☐ No ☐ Yes

Did the patient have surgery under general anesthesia? ☐ No ☐ Yes

If the patient stayed more than two nights before or after their appointment/treatment date, their medical practitioner or health service will need to sign question 21.

Treatment details

Name of specialist, allied health clinic, dentist, prosthetist/orthotists, high risk foot service, oral health clinic or clinical trial

Phone number ( )

Medicare provider number (only applicable for a specialist)

Treatment address

State Postcode

Part F. Travel and accommodation details

Please read before completing Part F. Travel and accommodation details.

17. **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 ➔ ***Go to question 19*** ☐ Yes ➔ Give details The escort's full name

18. **Does the escort have a concession card issued by Centrelink or DVA?**

☐ No ☐ Yes

Travel mode:		**People travelling:**	**Trip type:**
Private vehicle - PV	Community transport - CT	Patient only - P	One way - O
Public transport - PT	Emergency transport - ET	Escort only - E	Return - R
Commercial air - AIR	Taxi - TX	Patient and escort - PE	

19. **Travel dates**

Travel dates	**Travel mode**	**People travelling**	**Trip type**	**Address**	**Appointment date**	**Hospitalisation dates (if applicable)**	**Accommodation dates (if applicable)**	**Bulk bill**
Start / / End / /				From To	Start date / / End date / /	Admission / / Discharge / /	Check in / / Check out / /	☐
Start / / End / /				From To	Start date / / End date / /	Admission / / Discharge / /	Check in / / Check out / /	☐
Start / / End / /				From To	Start date / / End date / /	Admission / / Discharge / /	Check in / / Check out / /	☐
Start / / End / /				From To	Start date / / End date / /	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 the form '**Additional Travel and Accommodation Claims**' to submit additional trips. This can can be found on the IPTAAS website.

20. **Did the patient need to stay before or after the appointment or hospitaliston dates?** ☐ No ☐ Yes give details **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 19.
Otherwise this is optional and you may be audited for evidence confirming information at a later date.

21. **Medical practitioner or health service declaration**

I confirm: The information in part F is correct including appointment, hospitalisation and accommodation dates.

Full name of authorising person

Position

I understand that: Giving false or misleading information is an offence

Signature

Date D D/M M/Y Y Y Y

Part G. Payment details

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 23.

22. **Details of nominated bank account**

Account name

BSB number ☐☐☐ ☐☐☐

Account number ☐☐☐☐☐☐☐☐☐

23. **What part of the subsidy is to be paid to the third party organisation?** ☐ Travel ☐ Accommodation ☐ Both ☐ None

Third party organisation details

Name

Phone number ( )

ABN

Supplier number (if known)

Part H. 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.

24. **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

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 21 of this form I am required to keep evidence to prove I attended my appointment for two years

Giving false or misleading info rmation is an offence

Name of person completing this form

Signature

Date D D/M M/Y Y Y Y

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) 6766 4576
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 5270, Parramatta NSW 2124
Email: IPTAAS@health.nsw.gov.au
Location: over the counter assistance is also available in Dubbo at the Dubbo Base Hospital