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 C:** the patient's 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 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 referring 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

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. **Patient residential address** — State Postcode
7. **Patient postal address** (if different to residential) — State Postcode
8. **Patient contact details** — Email | 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. **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:

-This is the first application to IPTAAS for this practitioner or health service **OR**

-If the last time it was completed for this practitioner or health service was more than 2 years ago.

A separate form, including the referral details in this section must be submitted for each separate practitioner or health service that the patients see.

11. **Referring health professional's details** Full name | Phone number ( )

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

12.1 Is the practitioner or health service the nearest to the patient's residence? ☐ Yes ➔ ***Go to question 13*** ☐ No ➔ Give details below

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

13. **Health professional's 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.

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

Part E. Treatment details

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 one and answer applicable questions)

☐ **Specialist**
- Was the patient's treatment part of a non-commercial clinical trial? ☐ 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 (example Mammogram)? ☐ No ☐ Yes

☐ **Allied Health**

☐ **Dental**
- Does the patient have a cleft palate? ☐ No ☐ Yes
- Did the patient have surgery under general anaesthesia? ☐ No ☐ Yes

☐ **Prosthetic/Orthotic**
- Did the patient travel to a public hospital or public clinic? ☐ No ☐ Yes

☐ **High Risk Foot Services**

☐ **Oral Health Clinic**

Was the patient receiving palliative care? ☐ No ☐ Yes

Treatment details

Name of specialist, allied health clinic, dentist, prosthetist/orthotist, 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

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 ➔ Give details The escort's full name

Travel mode:		**People travelling:**	**Trip type:**	**Accommodation Type**
Private vehicle - PV	Community transport - CT	Patient only - P	One way - O	Private accommodation
Public transport - PT	Emergency transport - ET	Escort only - E	Return - R	(staying with family or friends)
Commercial air - AIR	Taxi - TX	Patient and escort - PE		Paid accommodation

17. **Travel dates**

Travel dates	**Travel mode**	**People travelling**	**Trip type**	**Address**	**Appointment date**	**Hospitalisation dates (if applicable)**	**Accommodation dates (if applicable)**	**Acc Type**
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 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 **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. Otherwise, this is optional, and the patient may be audited for evidence confirming information later. 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.

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 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

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.

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.

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

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