The patient's guide to the PTSS journey

STEP 1

Referral

- The patient needs to fill out the **PTSS Patient Registration Form (Form A) to register for PTSS.**

Tick when complete ☐

STEP 2

Assessment

The Clinician needs to fill out **PTSS Travel Referral Form (Form B)** for the patient to apply for travel, accommodation and patient escort subsidies.

- online at **www.health.qld.gov.au/ptss** or,
- at any Queensland public hospital or health facility in person or via email, fax or post.
- The patient's application is assessed against the PTSS policy to decide eligibility or alternatives to travel. The patient is notified of the outcome of their application, usually within a week.

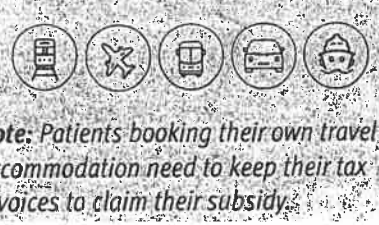
Tick when complete ☐

STEP 3

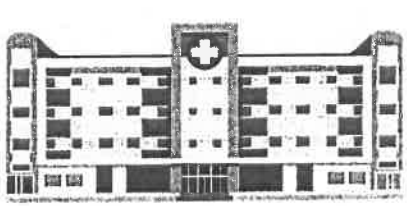
Booking

- Once the patient has their appointment date they should contact their local hospital or health facility about travel bookings.

Tick when complete ☐



- ***Note:** Patients booking their own travel or accommodation need to keep their tax invoices to claim their subsidy.*

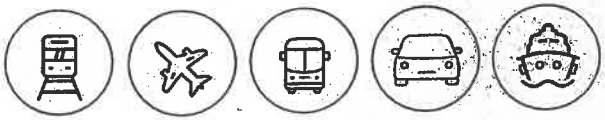


STEP 4

Attendance

- The **PTSS Appointment Attendance (Form C)** needs to be filled out and signed by the specialist, or a representative, to confirm the patient's attendance at the appointment.

Tick when complete ☐



STEP 5

Subsidy payment

Tick when complete ☐

- To claim their subsidy payment, the patient needs to submit their signed **PTSS Appointment Attendance (Form C)**, along with any tax invoices from travel and accommodation bookings.

These documents can be submitted:

- online at **www.health.qld.gov.au/ptss** or
- at any Queensland public hospital or health facility in person or via email, fax or post.
- Subsidy payment should be received within 30 business days of submitting all necessary and completed paperwork.

For more information on PTSS, including details on the process and contact details for Queensland Health facilities please visit **www.health.qld.gov.au/ptss** or call **13 HEALTH (13 43 25 84)***.
*If this number does not connect from your location please call **13 43 25** instead.

What is the Patient Travel Subsidy Scheme (PTSS)?

The Scheme PTSS provides financial support for patients to get specialist medical treatment when the service is not available within 50km of the patient's closest public hospital or public health facility.

Eligible patients can apply for travel and/or accommodation subsidies to help with the costs of getting to and from the closest public hospital or health facility where the specialist medical treatment is available. Patients who need help when travelling can also apply for a patient escort to travel with them.

The PTSS does not cover the full costs of travelling for specialist medical treatment. Any costs incurred in addition to approved subsidies are at the patient's expense.

Am I eligible for PTSS?

Patient must be a Queensland resident, or have no fixed address, and be eligible for Medicare to receive PTSS subsidies.

They must also have a valid referral for an approved PTSS specialty, that is not available within 50km of their nearest public hospital or health facility.

What subsidies are available?

Travel and accommodation subsidies are available for eligible patients and their patient escort. Patients should apply for PTSS as early as possible prior to travel.

Eligible patients can submit one retrospective application for assessment for travel undertaken in the last 12 months. **The approved travel subsidy** is for the most clinically appropriate and cost-effective mode of transport available, and is calculated using the rates on the table to the right.

Mode of transport	Subsidy amount
Commercial— air, bus, ferry or rail	Fully subsidised payment*
Private car (driving)	A rate of $0.30 per km, calculated using a predetermined toll-free route between facilities.

* equal to the lowest economy rate (excluding GST)

The accommodation subsidy provides financial support for accommodation costs for as long as the patient is medically required to be away from home and is calculated using the rates below:

Type of accommodation	Subsidy amount *per approved person
Commercial accommodation	Up to $60 per night
Private accommodation	$10 per night

Note: *Patients and patient escorts must pay for the first four nights of accommodation each financial year unless the patient holds a PTSS eligible concession card or is under 18 years of age.*

The accommodation subsidy does not apply to any nights the patient spends in hospital. Patient escorts may still be eligible during this time.

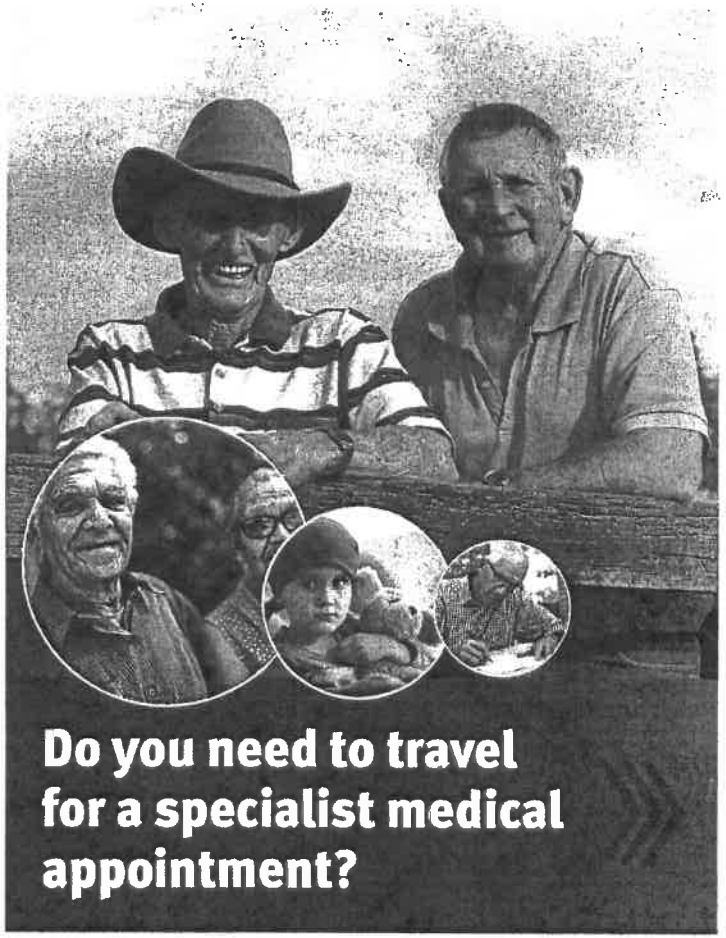
My PTSS ID is:

My local hospital or health facility is:

Their phone number is:

Their email address is:

SC2000642 Updated 31-03-2021



Do you need to travel for a specialist medical appointment?

If you are a permanent Queensland resident, and have a referral to a specialist medical service that is not available locally, you may be eligible for financial support as part of the Patient Travel Subsidy Scheme (PTSS).

For more information visit:

www.health.qld.gov.au/ptss
or call 13 HEALTH (13 43 25 84)

Queensland Government

User guide – **Patient registration (Form A)**

Use this step-by-step-guide to register for the Patient Travel Subsidy Scheme (PTSS). The purpose of this form is to register or update patient details in the PTSS system. This form only needs to be completed once, unless updating existing patient details. This form is not an application for PTSS.

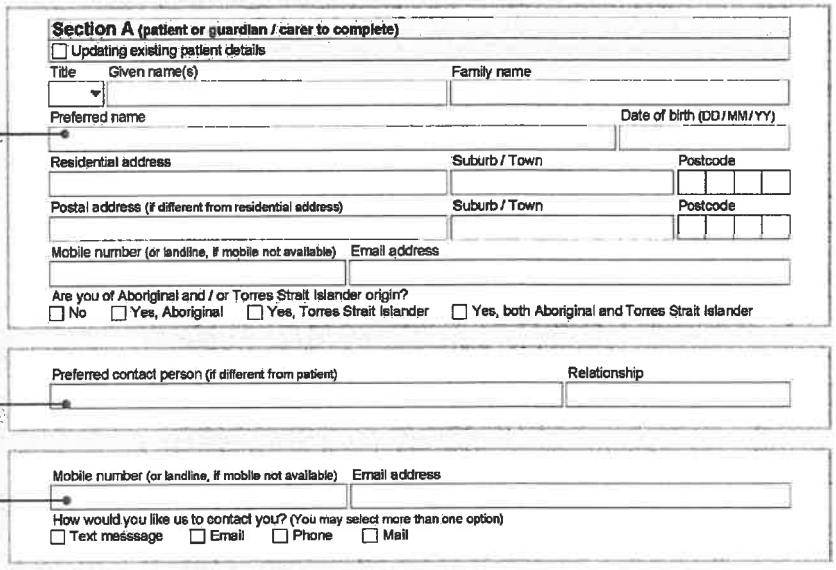
Section A

1. Please provide the patient's personal details.

   The preferred name is only required if it differs from the patient's given name.

2. Preferred contact person, if different from the patient (e.g. parent, guardian, carer etc).

3. Please provide the preferred way for contacting the patient.



Section A (patient or guardian / carer to complete)

☐ Updating existing patient details

Title | Given name(s) | Family name

Preferred name | Date of birth (DD/MM/YY)

Residential address | Suburb / Town | Postcode

Postal address (if different from residential address) | Suburb / Town | Postcode

Mobile number (or landline, if mobile not available) | Email address

Are you of Aboriginal and / or Torres Strait Islander origin?
☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

Preferred contact person (if different from patient) | Relationship

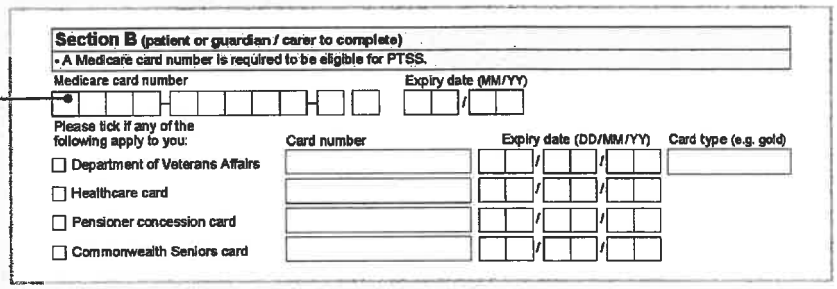
Mobile number (or landline, if mobile not available) | Email address

How would you like us to contact you? (You may select more than one option)
☐ Text messsage ☐ Email ☐ Phone ☐ Mail

Section B

4. This section must be completed.

   To be eligible for PTSS you must be eligible for a Medicare card



Section B (patient or guardian / carer to complete)

- A Medicare card number is required to be eligible for PTSS.

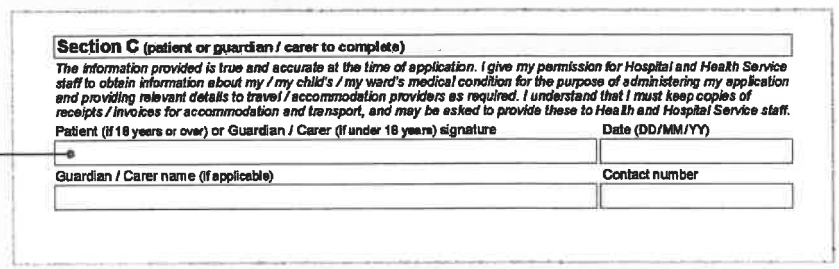
Medicare card number | Expiry date (MM/YY)

Please tick if any of the following apply to you:

	Card number	Expiry date (DD/MM/YY)	Card type (e.g. gold)
☐ Department of Veterans Affairs			
☐ Healthcare card			
☐ Pensioner concession card			
☐ Commonwealth Seniors card			

Section C

5. This form needs to be signed by the patient or their guardian/carer.



Section C (patient or guardian / carer to complete)

The information provided is true and accurate at the time of application. I give my permission for Hospital and Health Service staff to obtain information about my / my child's / my ward's medical condition for the purpose of administering my application and providing relevant details to travel / accommodation providers as required. I understand that I must keep copies of receipts / invoices for accommodation and transport, and may be asked to provide these to Health and Hospital Service staff.

Patient (if 16 years or over) or Guardian / Carer (if under 16 years) signature | Date (DD/MM/YY)

Guardian / Carer name (if applicable) | Contact number

*To apply for PTSS please fill out the **Travel referral (Form B).***
*To confirm your attendance at an appointment please fill out the **Appointment attendance (Form C).***

Queensland Government

Queensland Government
PTSS Hervey Bay
9:00am - 4:00pm Monday-Friday
P: 4325 6607 F: 4325 6780
E: frasercoast_travel@health.qld.gov.au

Patient Travel Subsidy Scheme (PTSS)

Patient registration (Form A)

Section A (patient or guardian / carer to complete)

☐ Updating existing patient details

Title:	Given name(s):	Family name:
Preferred name:		Date of birth (DD/MM/YYYY):
Residential address:	Suburb / Town:	Postcode:
Postal address (if different from residential address):	Suburb / Town:	Postcode:
Mobile number (or landline, if mobile not available):	Email address:	

Are you of Aboriginal and / or Torres Strait Islander origin?
☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

Preferred contact person (if different from patient):	Relationship:
Mobile number (or landline, if mobile not available):	Email address:

How would you like us to contact you? (You may select more than one option)
☐ Text message ☐ Email ☐ Phone ☐ Mail

Section B (patient or guardian / carer to complete)

• A Medicare card number is required to be eligible for PTSS.

Medicare number:	Expiry date (MM/YY):

Please tick if any of the following apply to you:

☐ Department of Veterans Affairs	Card number:	Expiry date (DD/MM/YY):	Card type (e.g. gold):
☐ Healthcare card	Card number:	Expiry date (DD/MM/YY):	
☐ Pensioner concession card	Card number:	Expiry date (DD/MM/YY):	
☐ Commonwealth Seniors card	Card number:	Expiry date (DD/MM/YY):	

Section C (patient or guardian / carer to complete)

The information provided is true and accurate at the time of application. I give my permission for Hospital and Health Service staff to obtain information about my / my child's / my ward's medical condition for the purpose of administering my application and to disclose relevant information, including a copy of this form, to approved travel / accommodation providers for the purpose of administration of the Patient Travel Subsidy Scheme (PTSS). I understand that I must keep copies of receipts / invoices for accommodation and transport, and may be asked to provide these to Hospital and Health Service staff.

Patient (if 18 years or over) or Guardian / Carer (if under 18 years) signature:	Date (DD/MM/YYYY):
Guardian / Carer name:	Contact number:

Hospital and Health Service use only

Identification number:

Proof of residency sighted / provided (e.g. QLD licence, electricity / gas bill, other acceptable documents)? ☐ Yes ☐ No
Concession card(s) sighted / provided? ☐ Yes ☐ No

Sighted by – staff name:	Signature:	Date (DD/MM/YYYY):

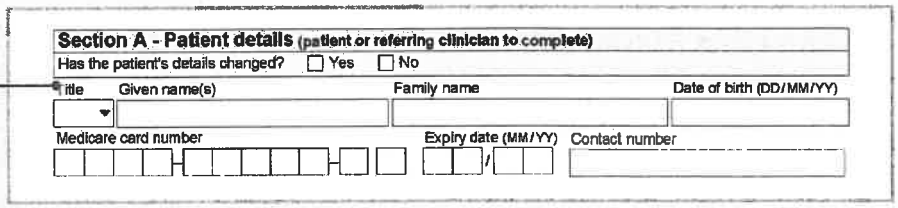
User guide – **Travel referral (Form B)**

Use this step-by-step-guide to the Travel referral (Form B) to apply for the Patient Travel Subsidy Scheme (PTSS). Parts of this form need to be completed by the clinician referring the patient. Information provided in this form will be used to determine the patient's eligibility for PTSS and their subsidy amount.

Section A

1. To update personal details the **Patient registration (Form A)**, needs to be filled out.

   Please provide the patient's personal details.



Section A - Patient details (patient or referring clinician to complete)

Has the patient's details changed? ☐ Yes ☐ No

Title | Given name(s) | Family name | Date of birth (DD/MM/YY)

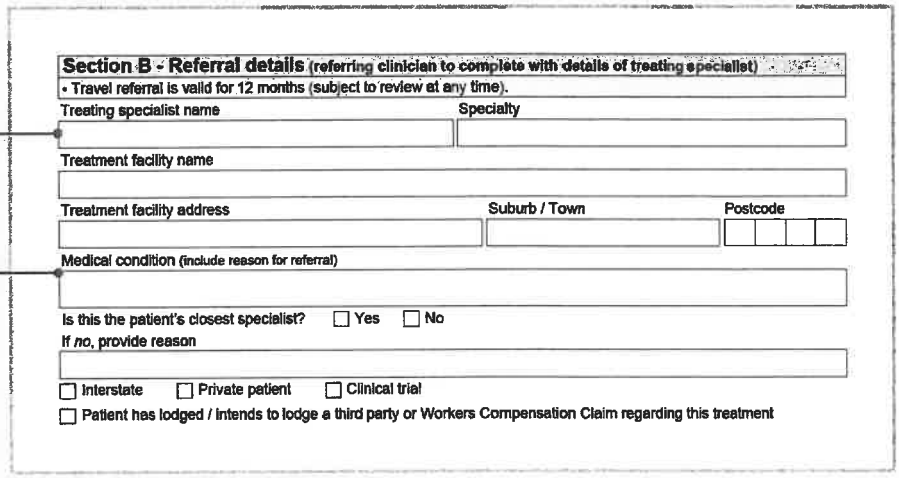
Medicare card number | Expiry date (MM/YY) | Contact number

Section B

2. This section needs to be completed by the clinician referring the patient.

   All fields need to be completed.

3. The medical condition section should also include any special conditions which may impact or influence where the patient receives treatment.



Section B - Referral details (referring clinician to complete with details of treating specialist)

• Travel referral is valid for 12 months (subject to review at any time).

Treating specialist name | Specialty

Treatment facility name

Treatment facility address | Suburb / Town | Postcode

Medical condition (include reason for referral)

Is this the patient's closest specialist? ☐ Yes ☐ No

If *no*, provide reason

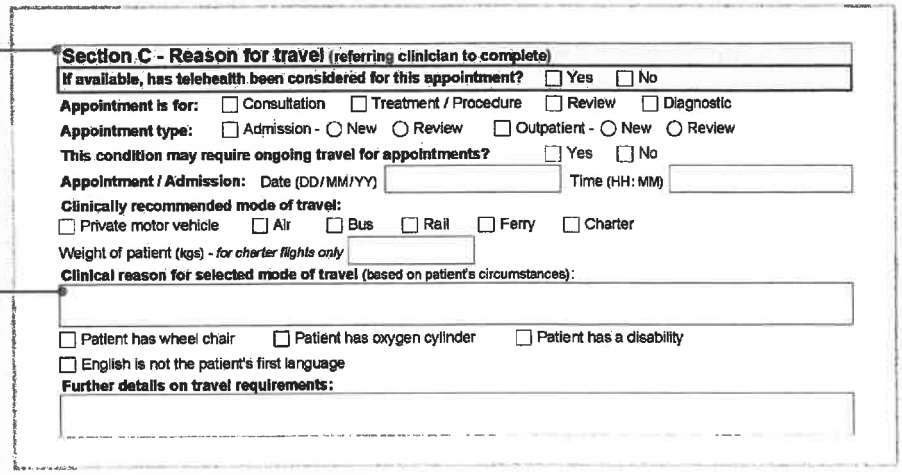
☐ Interstate ☐ Private patient ☐ Clinical trial

☐ Patient has lodged / intends to lodge a third party or Workers Compensation Claim regarding this treatment

Section C

4. This section needs to be completed by the clinician referring the patient. Providing more information will help a more informed decision to be made.

5. Clinical reason for selected mode of travel is important to complete if the patient's travel is restricted such as mobility, disability, health condition etc.



Section C - Reason for travel (referring clinician to complete)

If available, has telehealth been considered for this appointment? ☐ Yes ☐ No

Appointment is for: ☐ Consultation ☐ Treatment / Procedure ☐ Review ☐ Diagnostic

Appointment type: ☐ Admission - ○ New ○ Review ☐ Outpatient - ○ New ○ Review

This condition may require ongoing travel for appointments? ☐ Yes ☐ No

Appointment / Admission: Date (DD/MM/YY) | Time (HH:MM)

Clinically recommended mode of travel:

☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry ☐ Charter

Weight of patient (kgs) - *for charter flights only*

Clinical reason for selected mode of travel (based on patient's circumstances):

☐ Patient has wheel chair ☐ Patient has oxygen cylinder ☐ Patient has a disability

☐ English is not the patient's first language

Further details on travel requirements:

*To register or update a patient's personal details please use the **Patient registration (Form A)**.*
*To confirm patient attendance at an appointment please fill out the **Appointment attendance (Form C)**.*

Queensland Government

Section C

6 Further details on travel requirements can also be provided in this section such as accessibility requirements, restrictions to travel based on mode or distance, or if the patient requires assistance when travelling.

Further details on travel requirements:

Section D

7 This section needs to be completed by the clinician referring the patient.

This section should include any further details to support the patient's need for accommodation, including any further accommodation requirements.

Section D - Accommodation (referring clinician to complete)

Is the patient applying for a subsidy for accommodation*?

☐ Yes, private accommodation ☐ Yes, commercial accommodation ☐ Both ☐ No

Additional information (e.g. clinical reason to stay after appointment or discharge date, accommodation preference, etc.)

*As per the eligibility criteria. Approved by Hospital and Health Service.

Section E

8 This section needs to be completed by the clinician referring the patient.

9 The clinical reason for an escort needs to be completed.

Section E - Patient escort details (referring clinician to complete)

Is the patient applying for a Patient Escort*? ☐ Yes ☐ No

Patient escort details:

Title	Full name	Date of birth (DD/MM/YY)	Contact number

Clinical reason

Does the patient escort require accommodation?

☐ Yes, same as patient ☐ Yes, different to patient ☐ No

*As per the eligibility criteria. Approved by Hospital and Health Service.

Section F

10 Signature to certify information and acknowledgment of possible sharing of information.

Clinician or representative must sign this form as they are providing medical advice relating to the patient.

Section F - Declaration

Referring clinician (or clinicians nominated representative) declaration:

I certify that the information provided on this form is correct. I have advised the patient or guardian / carer that Hospital and Health Service staff may contact the referring facility and travel / accommodation providers regarding this referral.

Referring clinician / nominated representative name

(Clinician stamp)

Contact number | Facility name

Signature | Date (DD/MM/YY)

To register or update a patient's personal details please use the **Patient registration (Form A).**
To confirm patient attendance at an appointment please fill out the **Appointment attendance (Form C).**

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PTSS Hervey Bay
9:00am - 4:00pm Monday-Friday
P: 4325 6607 F: 4325 6780
E: frasercoast_travel@health.qld.gov.au

Patient Travel Subsidy Scheme (PTSS)

Travel referral (Form B)

Section A - Patient details (patient or referring clinician to complete)

Has the patient's details changed? ☐ Yes ☐ No

Title | Given name(s) | Family name | Date of birth (DD/MM/YY)

Medicare card number | Expiry date (MM/YY) | Contact number

Section B - Referral details (referring clinician to complete with details of treating specialist)

• Travel referral is valid for 12 months (subject to review at any time).

Treating specialist name | Specialty

Treatment facility name

Treatment facility address | Suburb / Town | Postcode

Medical condition (include reason for referral)

Is this the patient's closest specialist? ☐ Yes ☐ No

If *no*, provide reason

☐ Interstate ☐ Private patient ☐ Clinical trial

☐ Patient has lodged / intends to lodge a third party or Workers Compensation Claim regarding this treatment

Section C - Reason for travel (referring clinician to complete)

If available, has telehealth been considered for this appointment? ☐ Yes ☐ No

Appointment is for: ☐ Consultation ☐ Treatment / Procedure ☐ Review ☐ Diagnostic

Appointment type: ☐ Admission - ◯ New ◯ Review ☐ Outpatient - ◯ New ◯ Review

This condition may require ongoing travel for appointments? ☐ Yes ☐ No

Appointment / Admission: Date (DD/MM/YY) | Time (HH:MM)

Clinically recommended mode of travel:

☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry ☐ Charter

Weight of patient (kgs) - *for charter flights only*

Clinical reason for selected mode of travel (based on patient's circumstances):

☐ Patient has wheel chair ☐ Patient has oxygen cylinder ☐ Patient has a disability

☐ English is not the patient's first language

Further details on travel requirements:

Section D - Accommodation (referring clinician to complete)

Is the patient applying for a subsidy for accommodation*?

☐ Yes, private accommodation ☐ Yes, commercial accommodation ☐ Both ☐ No

Additional information (e.g. clinical reason to stay after appointment or discharge date, accommodation preference, etc.)

**As per the eligibility criteria. Approved by Hospital and Health Service.*

Section E - Patient escort details (referring clinician to complete)

Is the patient applying for a Patient Escort*? ☐ Yes ☐ No

Patient escort details:

Title	Full name	Date of birth (DD/MM/YY)	Contact number

Clinical reason

Does the patient escort require accommodation?

☐ Yes, same as patient ☐ Yes, different to patient ☐ No

**As per the eligibility criteria. Approved by Hospital and Health Service.*

Section F - Declaration

Referring clinician (or clinicians nominated representative) declaration:

I certify that the information provided on this form is correct. I have advised the patient or guardian / carer that Hospital and Health Service staff may contact the referring facility and travel / accommodation providers regarding this referral.

Referring clinician / nominated representative name

(Clinician stamp)

Contact number

Facility name

Signature

Date (DD/MM/YY)

Hospital and Health Service use only - Approval

Identification number

Subsidy approved for travel to: ☐ Place of referral ☐ Other

Mode of travel approved: ☐ Private motor vehicle ☐ Air ☐ Bus ☐ Train ☐ Ferry ☐ Other

Patient escort approved: ☐ Yes ☐ No

Accommodation approved: ☐ Yes ☐ No

☐ Private accommodation Number of nights approved: Patient Patient escort

☐ Commercial accommodation Number of nights approved: Patient Patient escort

☐ HHS to book ☐ Transport ☐ Accommodation ☐ Other

Has it been determined if a telehealth alternative exists for this patient? ☐ Yes ☐ No

If *no*, provide reason

Hospital and Health Service approval:

Approver name	Signature	Date (DD/MM/YY)
Approver name	Signature	Date (DD/MM/YY)

Special consideration - provide reason

Application not approved - provide reason

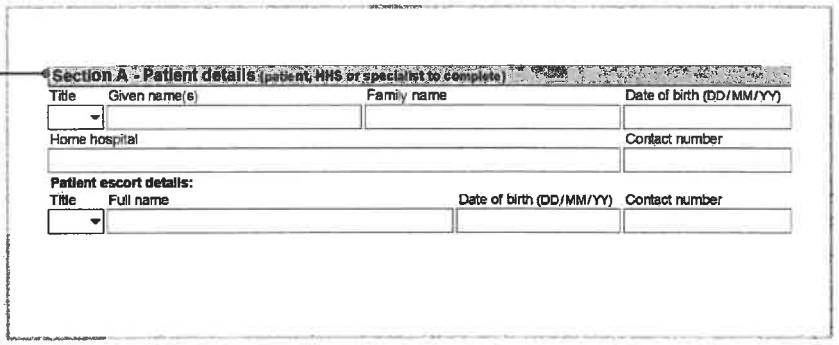
User guide – **Appointment attendance (Form C)**

Use this step-by-step-guide to the Appointment attendance (Form C) to certify the patient attended their specialist appointment. This form also confirms how long the patient was medically required to be away from home.

Section A

1. Please provide the patient's personal details

   To update personal details the **Patient registration (Form A)**, needs to be filled out.



Section A - Patient details (patient, HHS or specialist to complete)

Title	Given name(s)	Family name	Date of birth (DD/MM/YY)

Home hospital | Contact number

Patient escort details:

Title	Full name	Date of birth (DD/MM/YY)	Contact number

Section B

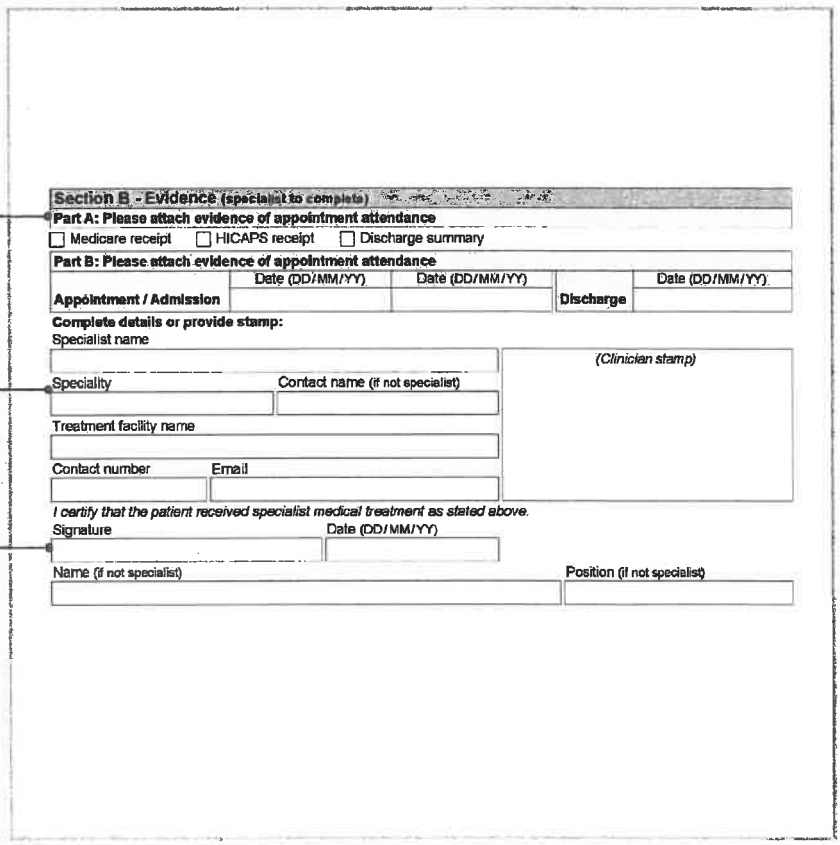
2. Either part A or part B needs to be completed.

   The patient can provide evidence for Part A and submit with this form.

   or

   The treating clinician needs to complete and sign part B.

3. Requires a signature from the specialist, representative or someone from the treating facility to certify the information provided in the form.



Section B - Evidence (specialist to complete)

Part A: Please attach evidence of appointment attendance

☐ Medicare receipt ☐ HICAPS receipt ☐ Discharge summary

Part B: Please attach evidence of appointment attendance

	Date (DD/MM/YY)	Date (DD/MM/YY)		Date (DD/MM/YY)
Appointment / Admission			**Discharge**	

Complete details or provide stamp:

Specialist name

(Clinician stamp)

Speciality | Contact name (if not specialist)

Treatment facility name

Contact number | Email

I certify that the patient received specialist medical treatment as stated above.

Signature | Date (DD/MM/YY)

Name (if not specialist) | Position (if not specialist)

*To register or update a patient's personal details please use the **Patient registration (Form A)**.*
*To apply for PTSS please fill out the **Travel referral (Form B)**.*

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Section C

4 The date the patient is medically approved to travel home.

Please provide reasons for the patient's requirement to travel after their discharge date (e.g. follow up appointments, admittance as an inpatient or not medically fit for travel).

Section C - Return travel (if travel not booked, specialist or treating HHS to complete)

Date ready to travel home (DD/MM/YY) ☐ Morning ☐ Afternoon — If not the same day as discharge, provide reason

Recommended return mode of transport: ☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry

If *air*, is a commercial flight medical clearance required? ☐ Yes ☐ No

Section D

5 To be completed by the treating clinician.

6 Please provide details of future appointments, if known.

More space for future appointments is provided on the back of this form.

Section D - Ongoing treatments (specialist to complete)

Has the patient's treatment been completed? ☐ Yes ☐ No

If *no*, can future appointments be provided via Telehealth? ☐ Yes ☐ No

Can ongoing treatment be provided at the patient's local hospital? ☐ Yes ☐ No

Details of next appointment *(if further appointments are required - continue in section E, page 2)*:

Date (approximate / TBA)	Appointment details (name / location)	Patient escort requested	Admission type	Appointment type	Speciality
		☐ Yes ☐ No	☐ Inpatient ☐ Outpatient	☐ Treatment ☐ Review ☐ Consultation	

Clinically recommended mode of travel: ☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry

Clinical reason for selected mode of travel:

Clinical recommendation for escort:

Section E

7 This section will notify the patient's home facility of future appointments and possible PTSS requirements.

It is to be filled in and signed by the specialist or a representative.

Section E - Additional appointment details (clinician / clinician's nominated representative to complete)

Admission		Admission type	Accommodation required	Patient escort required	Clinician declaration	
Date	Time (AM/PM)				Signature	Date
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		

To register or update a patient's personal details please use the ***Patient registration (Form A)****.*
To apply for PTSS please fill out the ***Travel referral (Form B)****.*

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9:00am - 4:00pm Monday-Friday
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E: frasercoast_travel@health.qld.gov.au

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Patient Travel Subsidy Scheme (PTSS)

Appointment attendance (Form C)

Section A - Patient details (patient, HHS or specialist to complete)

Title	Given name(s)	Family name	Date of birth (DD/MM/YY)

Home hospital | Contact number

Patient escort details:

Title	Full name	Date of birth (DD/MM/YY)	Contact number

Section B - Evidence (specialist to complete)

Part A: Please attach evidence of appointment attendance

☐ Medicare receipt ☐ HICAPS receipt ☐ Discharge summary

Part B: Please attach evidence of appointment attendance

	Date (DD/MM/YY)		Date (DD/MM/YY)
Appointment / Admission		**Discharge**	

Complete details or provide stamp:

Specialist name

Speciality | Contact name (if not specialist)

Treatment facility name

Contact number | Email

(Clinician stamp)

I certify that the patient received specialist medical treatment as stated above.

Signature | Date (DD/MM/YY)

Name (if not specialist) | Position (if not specialist)

Section C - Return travel (if travel not booked, specialist or treating HHS to complete)

Date ready to travel home (DD/MM/YY) ☐ Morning ☐ Afternoon

If not the same day as discharge, provide reason

Recommended return mode of transport: ☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry

If *air*, is a commercial flight medical clearance required? ☐ Yes ☐ No

Section D - Ongoing treatments (specialist to complete)

Has the patient's treatment been completed? ☐ Yes ☐ No

If *no*, can future appointments be provided via Telehealth? ☐ Yes ☐ No

Can ongoing treatment be provided at the patient's local hospital? ☐ Yes ☐ No

Details of next appointment *(if further appointments are required - continue in section E, page 2)*:

Date (approximate / TBA)	Appointment details (name / location)	Patient escort requested	Admission type	Appointment type	Speciality
		☐ Yes ☐ No	☐ Inpatient ☐ Outpatient	☐ Treatment ☐ Review ☐ Consultation	

Clinically recommended mode of travel: ☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry

Clinical reason for selected mode of travel:

Clinical recommendation for escort:

Hospital and Health Service use only Identification number

Section E - Additional appointment details (clinician / clinician's nominated representative to complete)

Date	Time (AM/PM)	type	required	required	Signature	Date
Admission		Admission type	Accommodation required	Patient escort required	Clinician declaration	
Date	Time (AM/PM)				Signature	Date
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Inpatient ☐ Outpatient	☐ Yes ☐ No	☐ Yes ☐ No		

Electronic Funds Transfer Payment Request

Queensland Government

Vendor Number:

Name:														
ABN (Business) or Date of Birth (Patient):														
Address:														
Suburb/Postcode:														
PO Box		Suburb					Postcode							
Telephone (home)					Telephone (mobile)									

Bank details

BSB Number:					-									
Bank Account Number:														
Bank Account Holder's Name:														
Email Address for payment advice:														

I authorise all future payments to be deposited directly into the above bank account. I will advise of any changes to the above bank details.

Businesses: For your protection, please support your bank details by supplying one of the following. Company letterhead with bank details or a copy of an invoice/bank deposit slip or Official Company Stamp.

	Witnessed by:
_____ **(Signature)**	_____ **(Signature)**
Name: _____	Name: _____
Date: ____/____/____	Date: ____/____/____

Please forward this completed request to your HHS/DoH contact:

Personal information collected by the Department of Health (DoH) is handled in accordance with the *Information Privacy Act 2009*. The DoH is collecting your personal information to process claims for payment. All personal information will be securely stored and only accessible by appropriately authorised officers of the department. Your personal information will not be disclosed to other third parties without consent unless the disclosure is authorised or required by or under law. For information about how DoH protects your personal information, or to learn about your right to access your own personal information, please see our website at www.health.qld.gov.au .