SECTION D - SPECIALIST TO COMPLETE

D

10. Oral Surgery

Where was the treatment provided? ____________ Medical item Nos ____________

11. Cleft Lip/Palate Patients

Patient's Registration No. ____________ Medical items Nos of treatment ____________

SPECIALIST TO SIGN SECTION C ON PREVIOUS PAGE

PLEASE FORWARD THIS APPLICATION TO YOUR REGIONAL P.A.T.S. OFFICE AS INDICATED BY NUMBERS BELOW.

2 • PATS
Port Lincoln Health and Hospital Services Inc.
PO Box 630
PORT LINCOLN SA 5606 (08) 8683 2266

3 • PATS
Whyalla Hospital & Health Services Inc.
PO Box 267
WHYALLA SA 5600 (08) 8648 8533

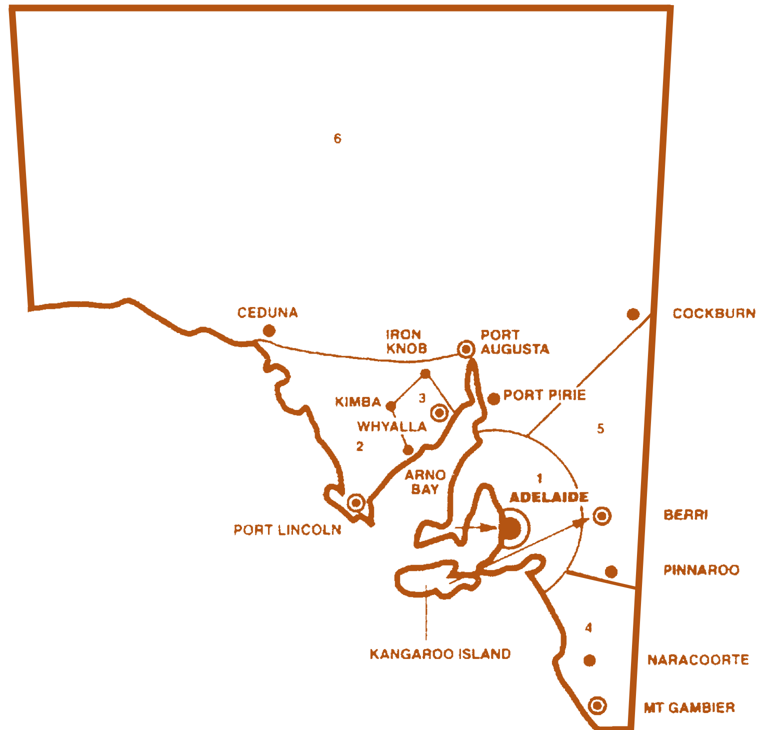
4 • PATS
Mount Gambier & Districts Health Service Inc.
PO Box 267
MOUNT GAMBIER SA 5290 (08) 8721 1551

5 • PATS
Riverland Regional Health Service Inc.
Maddern Street
BERRI SA 5343 (08) 8580 2400

6 • PATS
Port Augusta Hospital & Regional Health Services Inc.
Hospital Road
PORT AUGUSTA SA 5700 (08) 8648 5623

1 • PATS
Adelaide Office
PO Box 3017
Rundle Mall
ADELAIDE SA 5000 (08) 8226 6550

HEALTH CONSUMER SUPPORT OFFICE
FREECALL 1800 188 115



HWR 1673 / 16/04

DEPARTMENTAL USE ONLY

REGISTRATION No. ....

PATIENT'S NAME ....

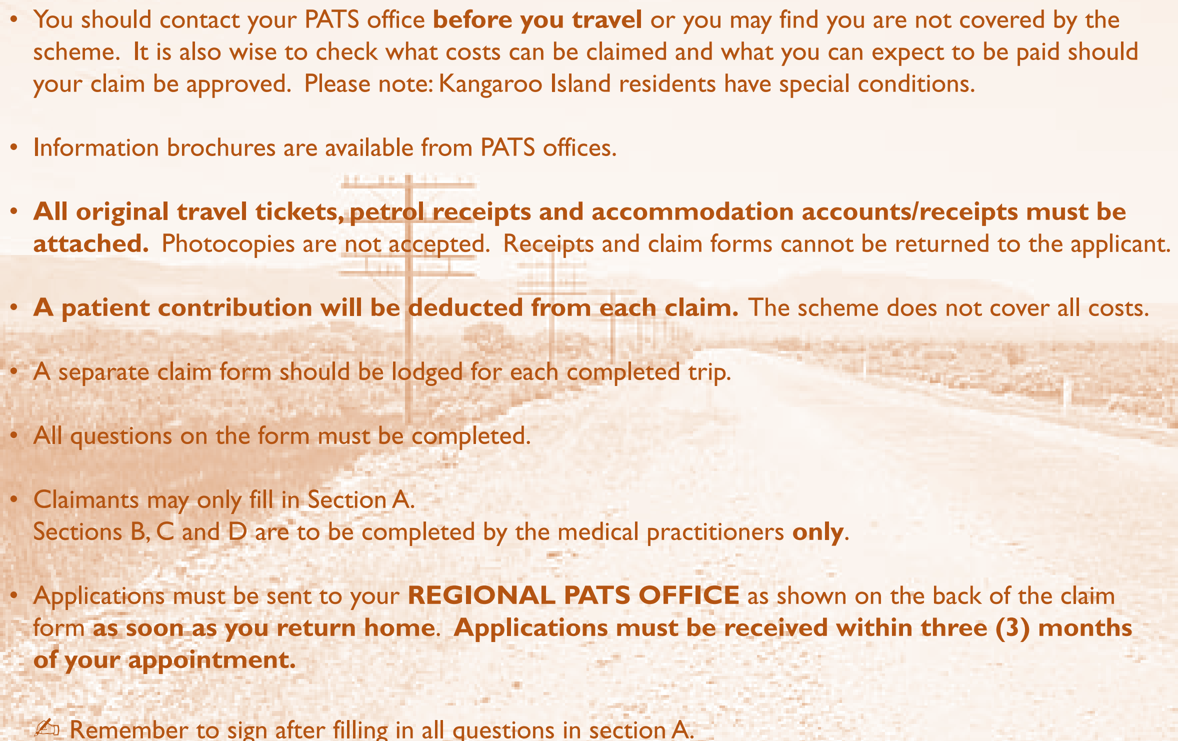
DEPARTMENT OF HEALTH

PATIENT ASSISTANCE TRANSPORT SCHEME

P.A.T.S.

APPLICATION FOR ASSISTANCE

FOR SOUTH AUSTRALIAN RESIDENTS ONLY



READ BEFORE YOU TRAVEL

- You should contact your PATS office **before you travel** or you may find you are not covered by the scheme. It is also wise to check what costs can be claimed and what you can expect to be paid should your claim be approved. Please note: Kangaroo Island residents have special conditions.
- Information brochures are available from PATS offices.
- **All original travel tickets, petrol receipts and accommodation accounts/receipts must be attached.** Photocopies are not accepted. Receipts and claim forms cannot be returned to the applicant.
- **A patient contribution will be deducted from each claim.** The scheme does not cover all costs.
- A separate claim form should be lodged for each completed trip.
- All questions on the form must be completed.
- Claimants may only fill in Section A.
  Sections B, C and D are to be completed by the medical practitioners **only**.
- Applications must be sent to your **REGIONAL PATS OFFICE** as shown on the back of the claim form **as soon as you return home**. **Applications must be received within three (3) months of your appointment.**

✍ Remember to sign after filling in all questions in section A.

September 2004

Government of South Australia

SECTION A - PATIENT DETAILS
APPLICANTS TO COMPLETE ALL QUESTIONS

1. Patient Details

Surname	Given Names
Address	Postcode
Date of Birth	Telephone No. (in case clarification of details is required) Home (Area Code) Work (if convenient) (Area Code)

2. Travel Concessions

Does the patient/escort receive any pension or benefit? YES ☐ NO ☐

If **YES**, answer these questions

Type of pension or benefit	Card No.	Department of Veteran's Affairs Card Colour white ☐ gold ☐

3. Escorts

Was the patient accompanied by one or more escorts? YES ☐ NO ☐

If **YES**, number of escorts ☐ Name of escorts ☐

4. Travel Details

I travelled from ☐ to ☐

Journey commenced on / / for an appointment at a.m./p.m. on / /

Returning home on / /

5. Method of Travel

Train ☐ Bus ☐ Ferry ☐ Air ☐ Amount paid $ ☐

Original tickets/receipts must be attached. Air travel will only be paid if medically endorsed, see 5B.

Private vehicle ☐ Original fuel receipts must be attached

Total distance travelled ☐ kms

If you reside on a property;
indicate the first town on journey ☐ The return distance from the property to that town is ☐ kms

6. Commercial Accommodation (private accommodation not payable) Original detailed receipt must be attached.

Please include a photocopy of both sides of Pension Concession Card/current Health Care Card if claiming accommodation.

No. of Nights	Rate per night $	Amount Paid $

7. All questions below must be answered

- Were all the expenses shown above actually paid by you? YES ☐ NO ☐
- Have you claimed or are you entitled to claim travel and/or accommodation benefits relating to this trip under
  (1) any other Commonwealth or State Scheme? YES ☐ NO ☐
  (2) Insurance, Third Party, Workers' Compensation etc? YES ☐ NO ☐
- Are you eligible to claim under any other travel and/or accommodation scheme operated by your employer? YES ☐ NO ☐

If YES what is the name of your employer? ☐

8. I DECLARE the above information is true and correct and understand that penalties exist for giving false or misleading information.

SIGNATURE OF CLAIMANT ☐ DATE / /

9. Please make the cheque for the total PATS benefit payable to:

Mr/Mrs/Miss/Ms ....
Address ....
.... Postcode ....

B

SECTION B - REFERRAL DETAILS
REFERRING PRACTITIONER TO COMPLETE

1. Referring Practitioner's Details

Practitioner's Surname	Initials	Provider No.	Telephone No.

Address

Postcode

2. I certify that

Patient's Name

Patient's Age

should be referred to

Type of Specialist

PLEASE NOTE: **PATS benefits are only payable if the referral is to the NEAREST REGISTERED MEDICAL SPECIALIST in that particular specialty**

Name of nominated specialist

Specialist's Suburb/Hospital

3. If the nominated specialist is not the nearest, but you consider there are valid medical reasons why the referral should be to this particular specialist, please provide details below:

4. Is an ESCORT medically necessary (YES or NO - please state)

5. If air travel is medically recommended please state reasons.

Signature of Referring Practitioner

DATE / /

C

SECTION C - REGISTERED MEDICAL SPECIALIST TO COMPLETE

6. Name of Practitioner completing this section

Telephone No.

Name of Practitioner who treated this patient

Provider No.

Specialty

Address where patient was treated

Postcode

7. Appointment date(s)

8. It is medically necessary for the PATIENT to remain for ____ nights in connection with present medical treatment

In your opinion is it desirable for an ESCORT to remain with the patient during this time? ____ (yes or no - please state)

9. Hospitalisation - Name of Hospital

Date of Admission / /

Pat. Unit Rec. No.

Date of Discharge / /

SIGNATURE OF TREATING SPECIALIST

DATE / /

FOR ORAL SURGERY OR CLEFT LIP/PALATE TREATMENT PLEASE COMPLETE RELEVANT SECTIONS OVERLEAF AND SIGN ABOVE.

SECTION D - SPECIALIST TO COMPLETE