



Dental benefit claim for the Medicare Teen Dental Plan



Instructions: only use this form for unpaid accounts or when not claiming in person or when authorising an agent to claim on your behalf.

You must attach original itemised accounts, receipts and voucher to this form.

Mail to **Medicare Australia, GPO Box 9822**, in your capital city, or place in the 'drop box' at your local Medicare office.

Patient's details—*The patient is the person who received the dental service*

1 Patient's Medicare card number

Ref no.	Patient's first given name	Services provided by e.g. Dr A P Jones	Account paid in full?
			No <input type="checkbox"/> Yes <input type="checkbox"/>
			No <input type="checkbox"/> Yes <input type="checkbox"/>
			No <input type="checkbox"/> Yes <input type="checkbox"/>

Claimant's details—*The claimant is the person who paid for, or is likely to pay for, the dental expenses. Benefits will be paid to this person.*

2 Is the claimant's Medicare card number the same as the patient's?

No Claimant's Medicare card number
Ref no.

Yes

3 Claimant's full name

Family name

First given name

Date of birth / /

Sex Male Female

OR Business name—for non-compensation claims if the claimant is an organisation/business that has incurred the expenses on behalf of the patient e.g. an approved care organisation

4 Postal address

Postcode

Do you want this recorded as your permanent Medicare Australia postal address? No Yes

5 Daytime phone number

6 Email (optional)

@

Payment of benefits—*It is important you provide your bank account details.*

7 Have you previously supplied your bank account details? No Yes

8 To supply or update your bank account details, please provide the following information. These details will be used for future payments.

Note: EFT cannot be paid into credit card or loan/mortgage accounts.

Name of bank, building society or credit union

Branch where account is held

Branch number (BSB) -

Account number (this may not be your card number)

Account held in the name(s) of

9 If you want a statement of benefit posted, please tick this box

Signature required overleaf

Claimant's declaration

10 I hereby claim benefits for the professional services to which this claim relates and
I declare that:

- I have paid for, or am liable to pay, the expenses for these services
- I have not claimed for these expenses through private health insurance
- to the best of my knowledge and belief all of the information in this claim is true and correct.

I understand that:

- it is an offence under the Dental Benefits Act 2008 to make a false statement relating to dental benefits.

Claimant's
signature

Date

11 Do you want to authorise another person (e.g. an agent) to collect benefits on your behalf?

Note: We will ask your agent to provide satisfactory personal identification before collecting benefits on your behalf.

No

Yes

Please give details of your agent

Full name

Address

Postcode

Agent's
signature

Claimant's
signature

Privacy note—the information provided on this form will be used to assess any dental benefit payable for the services rendered and may be used to update enrolment records. Its collection is authorised by the *Dental Benefits Act 2008*. The EFT details collected, will be stored and used for any future payments to you from programs administered by Medicare Australia. The information on this form may be disclosed to the Department of Health and Ageing, Centrelink, other relevant agencies, a person in the dental practice associated with this claim, or as authorised or required by law. The EFT details will not be disclosed to a third party unless authorised or required by law. Patient names and addresses may be disclosed to the relevant financial institutions when the claim is paid. Information about dental expenses for people under the age of 18 may also be disclosed to adults on the same Medicare card through taxation statements.

Organ Donor Registration (optional)

Australian
organ donor
register

1 Your Medicare card number

Your reference no.

2 Your details Family name

First given

Date of birth

Sex

Male

Female

3 I wish to register my consent to donate the following organs and/or tissues for transplantation, in the event of my death. Tick 'All' or as many as apply

All

Bone tissue

Eye tissue

Heart

Heart valves

Kidneys

Liver

Lungs

Pancreas

Skin tissue

4 I wish to register my decision **not to be** an organ and/or tissue donor

5 Would other members of your family like to register?

If you would like another form allowing up to four people who live at the same address to register, please visit www.medicareaustralia.gov.au or call **1800 777 203****.

6 Statement

- I give permission for all details I have provided to be included on the Australian Organ Donor Register.
- I have discussed this decision with my family, partner or friend.
- I am aware that I can change these details at any time.

Your
signature

Date

When we have processed your registration we will send a confirmation letter to your postal address recorded by Medicare Australia.

Further information

Visit Medicare Australia's website at
www.medicareaustralia.gov.au or call:

- Medicare **132 011***
- the Australian Organ Donor Register **1800 777 203****

Privacy note—The establishment of the Australian Organ Donor Register (the Donor Register) is authorised by a service arrangement under subsection 7(2) of the *Medicare Australia Act 1973*. The information on the Donor Register will be available to authorised personnel in the organ and tissue donation network who have signed confidentiality agreements covering your personal information.

* Call charges apply ** Call charges apply from mobile or pay phones only