



Reimbursement Form B

Submit your completed form to your local PATS office

☐ I am seeking reimbursement for below. Eligibility criteria applies. Forms must be lodged within 12 months of appointment.

Title	Surname		
Given name (s)	Preferred name		
Address			
Phone number			Date of birth
and/or			
Email address			
Bank Account	Account Name		
Details	6 Digit BSB No	Account No	

APPOINTMENT DETAILS Eligibility criteria applies. Including but not limited to the nearest specialist including telehealth or visiting specialist.

Appointment Date	Hospital/Clinic Location		
Speciality	Specialist Name		
for Cancer treatment	☐ Yes,	or renal dialysis	☐ Yes ☐ No
for radiology	☐ MRI	☐ Mammogram	☐ CT scan ☐ Ultrasound ☐ Nuc Med ☐ PET ☐ X Ray

If this travel related to Motor Vehicle Insurance or Workers Compensation eligibility criteria applies, please contact your local PATS Office.

TRAVEL & ACCOMMODATION DETAILS Eligibility criteria applies.

Transport	☐ Private vehicle	☐ Bus	☐ Train	☐ Air travel ¹
Departure Date			Return Date	
Accommodation	Please attach tax invoice/receipt required for commercial accommodation			
Recipient	to		☐ Private ²	☐ Commercial ³
Recipient	to		☐ In Hospital	
Support Person	to		☐ Private ²	☐ Commercial ³
Support Person	☐ Childbirth	☐ Cultural/linguistic support	☐ Cancer treatment	☐ Disability ☐ Under 18
for	Other, please specify			
Support Person	Name			Phone Number

¹Air travel eligibility; Photo ID is required for flights. Trips over 1200km one way are automatically eligible for air travel or over 350km one way if travelling for cancer treatment. Trips under 1200km one way will require supporting Clinical information for flights to be approved. ²Private Accommodation is to stay with family/friends. ³Commercial accommodation is at a hotel, motel, caravan. Please attach any relevant medical documentation to support your claim.

Recipient (or guardian) declaration and consent. I declare that the information provided is true and correct, and that PATS is not responsible for payment losses or fee/charges that may be incurred if incorrect banking details are provided. The expenditure claimed was incurred by me for the reasons outlined here and I am not entitled to claim or recover costs from any other source including compensation, insurance cover or damages. I give consent for WACHS staff to obtain or distribute information from/to any third party necessary for this application or to deliver relevant health care.

Signature Date

TO BE COMPLETED BY SPECIALIST OR CLINIC EMPLOYEE For every appointment claim to verify claim.

To facilitate reimbursement of expenses and/or confirm travel details complete all sections.

Has the recipient's condition changed so they require air travel?	☐ Yes	☐ No	☐ N/A
Has the recipient's condition changed so they require a support person?	☐ Yes	☐ No	☐ N/A
Has the recipient's condition changed so they need to extend their stay?	☐ Yes	☐ No	☐ N/A
Can the follow up appointments be done via telehealth?	☐ Yes	☐ No	☐ N/A
Was the recipient hospitalised?	☐ Yes, from	to	☐ No

If 'Yes' to any of the above, please provide clinical reason:

Stamp (required)	Signature
	Name Date

OFFICE USE ONLY	PATS Clerk	☐ Approved ☐ Declined	Reference #
	Delegated Financial Authority	☐ Approved ☐ Declined	Signature/ he #

THIS FORM IS AVAILABLE IN AN ALTERNATIVE FORMAT ON REQUEST