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## Section 19(2) Exemption - Patient Assignment of Medicare Benefit Guideline

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### 1. Purpose

The 'Improving Access to Primary Care in Rural and Remote Areas - Section 19(2) Exemptions Initiative' was implemented in 2006 by the Council of Australian Governments (COAG) and allows exempted eligible sites to claim against the Medicare Benefits Schedule (MBS) i.e. bulk bill for non-admitted, non-referred professional services (including nursing, midwifery, allied health and dental services) provided in emergency departments, hospital clinics and community settings at both Activity Based Funding (ABF) and non ABF sites.

The Initiative is governed by a [Memorandum of Understanding with the Commonwealth](#) and recognises that people living in rural and remote communities have limited access to primary health care services and many rural and remote public hospitals provide primary care services that would otherwise be available through alternate private providers in the community.

The aim of the exemption is to increase and improve primary health care services within these communities, which is achieved by optimising WA Country Health's (WACHS) capacity to access Medicare funds and the requirement that all funds derived from the Initiative are to be used to fund new or enhanced primary care services at the site. This may include funding of new/additional primary care services, purchase of equipment, capital improvements and staff training/supports.

Eligible services at [Section 19\(2\) exempt sites](#) are able to be bulk-billed to Medicare providing that all legislative requirements are met, including the assignment of benefits requirements. This requires that the recipient of the services (the patient) assigns their rights to the Medicare rebate to the servicing provider (the health practitioner providing the service) via the signing of a Medicare approved form.

**Note:** This requirement is not unique to this initiative and also applies to services bulk-billed Australia-wide under ordinary arrangements with Medicare.

### 2. Guideline

The guideline provides instructions, processes and recommendations for the completion of billing documentation, including the assignment of benefits form at Section 19(2) exempt sites.

#### 2.1 Scope

This guideline applies to all sites bulk-billing Medicare for non-admitted, non-referred services under a Section 19(2) exemption. Sites with current exemptions are listed on the [Business Services SharePoint page](#).

Services provided using the Community Health Information System (CHIS) or Best Practice software, which are billed to Medicare, must also comply with the assignment of

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benefit requirements. Instructions relating to CHIS and Best Practice are included in this guideline.

Radiology bulk-billing under a Section 19(2) exemption, or for privately referred services, should still comply with assignment of benefit requirements. Instruction on the process for radiology billing is not covered under this guideline as the process is dependent on the radiology service model and radiology information system installed at the site.

This guideline **does not** apply to private, compensable or ineligible patients whose services are not bulk billed to Medicare. Sites may use a common billing sheet to record these services, but the patient is not required to assign benefits for any services that are not being bulk billed to Medicare.

## 2.2 Medicare Requirements

Sites are responsible for ensuring that patients who receive eligible services assign their Medicare benefits in accordance with Medicare Australia requirements. It is important to note that the requirements for the assignment of Medicare benefits remain unchanged under the Section 19(2) exemptions initiative.

The legislative requirements for the assignment of benefit are:

- an agreement must be made between the patient (assignor) and the provider for the assignment of benefit
- the agreement is 'evidenced' through the use of the assignment of benefit form
- the patient is required to sign the form
- a copy of the agreement must be provided to the patient.

Patients must not be charged a co-payment (also known as a 'gap' or 'out of pocket') for services billed under this initiative.

## 2.3 Documentation Requirements

### Services in a Paper-Based Environment

Services provided in Emergency Departments and at some sites will not use CHIS or Best Practice and will complete paper-based billing forms. Sites will need to develop patient and form flows depending on staffing, existing practices and physical layout of the service setting.

The following pieces of information are required:

- WACHS Billing Sheet
- the Medicare DB4 Assignment of Benefits Form (printable 2 to a page).

It is recommended that these are printed separately so there is no need to photocopy the billing sheet to meet the legislative requirement; "a copy of the agreement must be provided to the patient"<sup>1</sup>.

It is acknowledged that there is some level of duplication required in the completion of the two forms. If there is a limited number of regular service providers, forms could be preprinted with the provider's name and provider number.

A local approach is required to ensure all billable services are identified and recovered from Medicare Australia. The administration staff, health worker, nurse, doctor and patient all play a role in ensuring that the required paperwork is completed to meet the legislative requirements.

### Completion of the WACHS Billing Sheet

The billing sheet is for internal use and is used to provide billing information for data entry into Patient Billing & Revenue Collection (PBRC) for billing to Medicare. The billing sheet is a form which can be customised at each site based on the services typically presenting to that site. An example can be found on the Section 19(2) Exemption Resources [Business Services SharePoint page](#). The form must include the following:

- patient details/sticker
- date, start time, and end time of the consultation
- name and signature of the service provider (the signature verifies that the provider has assigned the item numbers and performed the consultation)
- item numbers of all services provided to the patient; these must only be entered by the practitioner whose provider number is being used to bill the services.

### Completion of the Medicare DB4 Assignment of Benefits Form

The patient assigns their benefit using the [DB4 form](#).

**Note:** the DB4 does not replace the billing sheet and is given to the patient to satisfy the assignment of benefit requirement “a copy of the agreement must be provided to the patient”<sup>1</sup>.

The form requires the following (as shown in [illustration 1](#)):

- patient details/sticker
- Medicare number
- Patient Reference number (the number next to the person’s name on their Medicare card which is also the last digit recorded of their Medicare number on WebPAS/CHIS)
- date of service
- service items (these would be the same as those ticked on the billing sheet), item numbers only required
- provider name and s19(2) linked Provider Number OR address e.g. Dr James 12345GK OR Dr James Anytown Hospital, sites may choose to pre fill this information for each participating doctor and then copy the forms
- patient signs the form after the service has been provided, the patient must not sign a blank or incomplete assignment of benefit form
- patient is given the form to take.

**Note:** other fields not listed above do not need to be completed



- If present, the health professional supporting the patient during the telehealth consultation (receiving end) can ask the patient to sign the form (DB4) and return it to you.

### Patient Unable to Sign<sup>2</sup>

Where a patient is unable to sign the assignment of benefit form:

- the signature of the patient's parent, guardian or other responsible person (other than WACHS staff) is acceptable
- in the absence of a "responsible person" the patient signature section should be left blank.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include the notation "Patient unable to sign" and in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand, infectious etc.) This note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality, or unduly embarrass or distress the patient, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases, it is expected that the reason given will be more specific.

## 2.4 Audit

The patient will never be asked for a copy of the assignment of benefits form by Medicare. From Medicare Australia, "If we need to confirm that the service was provided to a patient, we will seek alternative evidence from you that the service was provided. Evidence may include electronic billing information, notes in practice software appointment records, and, if the practice chooses to retain them, the copy of the assignment of benefit form."<sup>1</sup>

As WACHS uses Medicare Online (via PBRC) there is no legal requirement for WACHS to store the assignment of benefit forms or copies of the form<sup>1</sup>.

WACHS has sought advice from Medicare regarding the assignment of benefits process given the lack of audit on the completed forms that are given to the patient and have been advised that this process is a legislative requirement and no exemption from this process is available.

## 3. Roles and Responsibilities

**WACHS Finance** is responsible for ensuring this information remains up to date with current legislative requirements and aligns with the Section 19(2) exemption Memorandum of Understanding.

**Sites** are responsible for:

- implementing local processes which fulfill the requirements outlined in this guideline
- ensuring relevant staff are aware of the legislative requirements in respect to these processes
- monitoring and evaluating these processes to ensure continued compliance with the requirements set out in this guideline.

**Participating Medical Officers** and **eligible health professionals** are responsible for:

- compliance with Medicare Australia rules in respect to the assignment of Medicare benefits from the patient
- allocation of appropriate MBS item numbers including the rural practice bulk bill incentive item where it applies.

**All staff** are required to comply with the directions in WACHS policies and procedures as per their roles and responsibilities. Guidelines are the recommended course of action for WACHS, and staff are expected to use this information to guide practice. If staff are unsure which policies procedures and guidelines apply to their role or scope of practice, and/or are unsure of the application of directions they should consult their manager in the first instance.

#### 4. Monitoring and Evaluation

This guideline will be monitored and evaluated by WACHS Finance every two years to reflect any amendments to the Memorandum of Understanding (MOU).

#### 5. References

1. [Medicare Online for Health Professionals](#)
2. [Medicare Benefits Schedule](#)
3. [Medicare Bulk Billing Telehealth](#)
4. [WA Health MBS Billed Non-Admitted Services Manual](#)

#### 6. Definitions

Nil

## 7. Document Summary

<b>Coverage</b>	WACHS-wide
<b>Audience</b>	Section 19(2) Exempt Sites
<b>Records Management</b>	Non Clinical: <a href="#">Corporate Recordkeeping Compliance Policy</a> Clinical: <a href="#">Health Record Management Policy</a>
<b>Related Legislation</b>	<a href="#">Health Insurance Act 1973</a> (Cth)
<b>Related Mandatory Policies / Frameworks</b>	<ul style="list-style-type: none"> <li>• <a href="#">Financial Management Framework</a></li> </ul>
<b>Related WACHS Policy Documents</b>	Nil
<b>Other Related Documents</b>	<ul style="list-style-type: none"> <li>• <a href="#">Memorandum of Understanding with the Commonwealth</a></li> <li>• <a href="#">Section 19(2) exempt sites</a></li> <li>• <a href="#">WA Health MBS Billed Non-Admitted Services Manual</a></li> </ul>
<b>Related Forms</b>	<ul style="list-style-type: none"> <li>• <a href="#">DB4 form</a></li> </ul>
<b>Related Training</b>	Nil
<b>Aboriginal Health Impact Statement Declaration (ISD)</b>	ISD Record ID: 4616
<b><a href="#">National Safety and Quality Health Service (NSQHS) Standards</a></b>	1.7c
<b><a href="#">Aged Care Quality Standards</a></b>	Nil
<b><a href="#">Chief Psychiatrist's Standards for Clinical Care</a></b>	Nil
<b>Other Standards</b>	Nil

## 8. Document Control

Version	Published date	Current from	Summary of changes
1.00	17 August 2020	17 August 2020	New guideline
2.00	26 May 2026	26 May 2026	Formal review <ul style="list-style-type: none"> <li>• general review and update to links</li> </ul>

## 9. Approval

<b>Policy Owner</b>	Executive Director Business Services
<b>Co-approver</b>	Executive Director Clinical Excellence Chief Operating Officer
<b>Contact</b>	Manager Revenue Enhancement
<b>Business Unit</b>	Finance
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