WA Country Health Service
Department of Primary Industries and Regional Development
GOVERNMENT OF WESTERN AUSTRALIA

Patient Assisted Travel Scheme (PATS)

Registration and Recipient Details Form A

Submit your completed form to your local PATS office

☐ I am **applying for PATS** for the first time, or ☐ a current PATS recipient **updating my details**

REQUIRED if completing Form A

Title **Surname**

Given name (s) **Preferred name**

Date of birth **Sex**

Email address
and/or
Phone number

Permanent residential address

If registering for first time or updating residential address, please attach proof of address via one of the following: drivers license, health care card, current lease agreement or utility bill for gas, internet or electricity that states applicant name and supply address.

Postal address if different from above

Person under 18 parent or guardian
Name _____
Phone _____

Recipient Declaration (or Parent/Guardian) I confirm that PATS is not responsible for payment losses or fee/charges that may be incurred if incorrect banking details are provided and I declare that the information provided is true and correct.

Signature: **Date:**

REQUIRED if completing Form A and registering for first time or if details have changed since last application

Medicare Card Number _____
Individual reference number _____ Expiry Date _____

Veteran Affairs Card ☐ White ☐ Gold DVA card holders should contact DVA in the first instance
Number _____ Expiry Date _____

Pensioner or concession card Type _____
Number _____ Expiry Date _____

Bank Account Details
Account Name _____
6 Digit BSB No _____
Account No

Do you identify as Aboriginal and/or Torres Strait Islander?
☐ Aboriginal ☐ Torres Strait Islander
☐ Aboriginal & Torres Strait Islander ☐ Prefer not to say
☐ Neither

Privacy: WA Country Health Service (WACHS) will review and confirm the details you provide to assess your PATS requests. Your information is stored within a secure system. WACHS staff may obtain or distribute information from/to any third party necessary for this application or to deliver relevant health care. Further information is provided in the Department of Health Privacy Statement.

OFFICE USE ONLY ☐ Sighted proof of residency PATS Clerk signature / he # _____

THIS FORM IS AVAILABLE IN AN ALTERNATIVE FORMAT ON REQUEST