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

Patient Assisted Travel Scheme (PATS)

# Reimbursement

## Form B

☐ 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**
and/or
**Email address**

**Date of birth**

Preferred reimbursement method? ☐ Cheque ☐ Direct deposit, complete below 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

**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 details** ☐ 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** for ☐ Cancer treatment ☐ Cultural/linguistic support ☐ Childbirth ☐ Disability ☐ Under 18 ☐ Other, please specify

Support Person Name Phone Number

*[1]Air travel eligibility; 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. [2]Private Accommodation is to stay with family/friends.*
*[3]Commercial accommodation is to stay at hotel, motel, caravan park. If required 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, 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 recpient'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

Was the recipient hospitalised? ☐ No ☐ Yes, from ____ to ____

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

Can the follow up appointments be done via telehealth? ☐ Yes ☐ No

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