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

Patient Assisted Travel Scheme (PATS)
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 and/or **Email address** _____ **Date of birth** _____

Bank Account Details Account Name _____

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 for ☐ Childbirth ☐ Cultural/linguistic support ☐ Cancer treatment ☐ Disability ☐ Under 18

Other, please specify _____

Support Person Name _____ Phone Number _____

[1]Air 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. [2]Private Accommodation is to stay with family/friends. [3]Commercial 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

Clear Form