

## Form 1: Application for travel and accommodation subsidies (individual appointment)

PATS OFFICE USE.

Claim number:







Received date:

### Part A. Patient details (patient/guardian to complete)

Patients receiving financial assistance for travel and accommodation from other agencies are not eligible for PATS.

If you tick yes to receiving assistance from another government or third-party provider, please do not complete this form.

**1. Have you received, or are you eligible to receive, financial assistance for travel and accommodation from:**

An Australian, state or territory government scheme other than PATS?

No  Yes

Department of Veterans' Affairs?

No  Yes

Workers compensation?

No  Yes

As part of a third-party insurance claim, private health insurance or any other insurance claim?

No  Yes

**2. Have you submitted a PATS claim before?** No  Yes  If yes, please provide your client number (if known)

Have any of your details changed since you last submitted a claim (bank account, contact details etc) No  Yes

**3. Your name**

Title

Given name

Middle name




Surname

DD / MM / YYYY

**4. Your date of birth**

**5. Your Medicare number**

Individual reference number

**6. Do you have a pension or health care card?** (please provide a current copy if you have not already done so)

Card no.

Expiry

**7. Your residential address**



Post code





**8. Your postal address**

(if different to residential)



Post code





**9. Your contact details** Email

Phone

Mobile

**10. Do you identify as Aboriginal or Torres Strait Islander?**

No  Yes

**11. Are you an Australian citizen or permanent resident?**

No  Yes

**12. Bank details**

Account holder's name

BSB

Account number

What is your preferred method of remittance?

Email

SMS

## Part A. Patient details cont. (patient/guardian to complete)

### Travel and accommodation details

Please provide tax invoices for accommodation and mode of travel (fuel receipts **not** required).

13. Your travel details	Forward trip		Return trip	
	Client	Escort	Client	Escort
Mode of travel				
Private vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medically authorised air	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bus/coach/rail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ferry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community car/bus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Treatment location

15. Escort name

16. Patient travel dates

Forward date	Return date
<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>

17. Escort travel dates

Forward date	Return date
<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>

18. Are you claiming accommodation? No  Yes

Check in	Check out
<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>

19. Are you claiming escort accommodation? No  Yes

Check in	Check out
<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>

20. Please provide any further information to support your claim

### Patient declaration and privacy (patient/guardian to complete)

The information contained in this application is protected by law from unauthorised access and misuse. The information will only be accessed by health service staff directly involved in providing services to the applicant, or with other lawful excuse.

Patient/Guardian name

I declare that the information I have provided in this form is complete and correct and that all documents provided are genuine. I understand that the Rural Support Service may make relevant enquiries to assess this application and make sure I receive the correct subsidy, and that giving false or misleading information is an offence.

Signature	Date
<input type="text"/>	<input type="text" value="DD / MM / YYYY"/>

## Part B. Referring practitioner details (MUST be completed by referring practitioner or authorised representative )

Please note: Part B is only required to be completed when the patient is bypassing a nearer specialist service (including radiology appointments). Patients must be referred to their nearest treating medical specialist. If a patient is required to bypass their nearest specialist, the referring practitioner must provide a valid medical reason for approval.

20. Name of patient

21. Referring practitioner details Full name

Phone number

22. Specialist Treatment details

Name of the medical specialist or approved medical specialist service you referred the patient to

Treatment location

Type of treatment referred for

23. Is the specialist or specialist service (including Radiology) the nearest one to the patient's residence? No  Yes

(If no, please provide a valid medical reason)

\* The timeframe to be seen locally is clinically unacceptable.

\* The patient's clinical risks cannot be managed in a regional South Australian health facility.

\* The patient cannot be treated in South Australia.

24. Referring practitioner declaration (to be completed by the referring practitioner or their authorised representative).

I declare that the information provided in Part B of this form is complete and correct and that I understand giving false or misleading information is an offence.

Referring practitioner stamp

Signature

Date

## About PATS

### About PATS

PATS is a subsidy program funded by the Government of South Australia and administered through the six regional local health networks by the Rural Support Service. Through PATS, subsidies are provided to assist South Australians who are required to travel more than 100km each way to access necessary and approved medical specialist services that are not available locally.

### Use our online services

You can apply online instead of completing this paper form. To register to use our online services, visit our website at [www.pats.sa.gov.au](http://www.pats.sa.gov.au)

### When to use this form

You should use Form 1 if you are claiming for an individual appointment with a specialist. If you are claiming for multiple appointments with the same specialist (block treatment), please use Form 2.

### Important information

- Applications must be submitted within six months of your appointment date.
- Patients are supported to access their nearest medical specialist only, unless there is a valid medical reason for bypassing this service, in which case your referring doctor must complete Part B of this form.
- PATS is unable to guarantee eligibility prior to a full assessment of your claim.
- We will require tax invoices for accommodation and mode of travel (excluding petrol receipts). Please submit these with your completed form.
- The standard processing time for a claim is four weeks.

### More information

Visit [www.pats.sa.gov.au](http://www.pats.sa.gov.au) or call 1300 341 684.

## Part C. Treating specialist details (MUST be completed by treating specialist or authorised representative)

25. Name of patient

### 26. Treating specialist details

Full name

Medical Speciality/Hospital Department

Medicare provider number

AHPRA number

Treatment location/address

Postcode

Phone

27. Was this an initial assessment or visit? No  Yes

### 28. Appointment / Treatment date (s)

Appointment date/ Treatment start

Treatment end

### 29. Was the patient hospitalised?

No  Yes If Yes – please provide dates

Admission

Discharge

30. Did the patient require an escort? No  Yes  Reason

If a patient requires an escort, the specialist must provide a valid medical reason.

Examples: **impairment, active role of carer, client is a child, necessary assistance or as an alternative to air travel.**

31. Was the patient required to travel by air? No  Yes  Reason

If a patient is required to travel by air, the specialist must provide a valid medical reason.

Examples: **active clinical management, pain management, clinical urgency or restricted mobility.**

32. Did the patient require more than two nights of accommodation? No  Yes  Total number of nights

If a patient is required to stay longer than two nights in commercial accommodation, the specialist needs to indicate the total number of nights per stay authorised, in order for subsidies to be provided for additional nights.

33. Please provide any further information to support the claim. (If radiology - what type of service i.e. MRI, Nuclear Medicine, Mammogram, Ultrasound guided procedure, and reason why it could not be provided locally)

### 34. Treating specialist declaration

I declare that the information provided in Part C of this form is complete and correct and that I understand giving false or misleading information is an offence.

Signature

Date

Treating specialist stamp

## Submitting your application

Check that all required questions are answered, the form is signed and dated and relevant tax receipts and supporting documents are included. You can submit your application online via [www.pats.sa.gov.au](http://www.pats.sa.gov.au), by email at [pats@sa.gov.au](mailto:pats@sa.gov.au) or to your local PATS office by post.

#### Adelaide Office

PO Box 3017, Rundle Mall  
ADELAIDE SA 5000

#### Mount Gambier and District Health Service

276–300 Wehl Street North / PO Box 267  
MOUNT GAMBIER SA 5290

#### Port Augusta Hospital and Regional Health Service

71 Hospital Road  
PORT AUGUSTA SA 5700

#### Port Lincoln Hospital and Health Service

Oxford Terrace / PO Box 630  
PORT LINCOLN SA 5606

#### Riverland General Hospital

10 Maddern Street  
BERRI SA 5343

#### Whyalla Hospital and Health Service

Wood Terrace / PO Box 267  
WHYALLA SA 5600

For more information  
please visit  
[www.pats.sa.gov.au](http://www.pats.sa.gov.au)  
or scan the  
QR Code below.

