Australian Government
Department of Human Services

medicare

Request for Pharmaceutical Benefits Scheme claims information

Information about your request

The purpose of this form is to request Pharmaceutical Benefits Scheme (PBS) claims information for individuals and families.

Any changes to this form must be initialled by the relevant signatory.

You can view, download and print your PBS claims information for at least the last 2 years by accessing your My Health Record.

For more information, go to **myhealthrecord.gov.au**

This form should only be used to request PBS claims information which you are unable to access via your My Health Record.

If you are requesting PBS claims information for a person (other than children under 14 years of age) who cannot consent to the release of their own information (e.g. they have a power of attorney or they are deceased), in addition to completing this form, please provide evidence of your authority to act on their behalf.

Information that may be provided in response to your request will include prescribing date, supply date, item description, quantity of repeats, prescriber names and pharmacy name and address.

Filling in this form

- **Please use black or blue pen**
- Print in BLOCK LETTERS
- Mark boxes like this ☐ with a ✓ or ✗
- Where you see a box like this ☐ ***Go to 5*** skip to the question number shown. You do not need to answer the questions in between.

Returning your form

Check that all required questions are answered and that the form is signed and dated.

If you have indicated that the information requested in this form should be provided to a third party, please return this completed form to that third party.

The third party is responsible for sending this completed form to the email address below.

Email the completed form to:
medicare.disclosure@humanservices.gov.au

or

visit one of our service centres.

For more information

For more information, go to **humanservices.gov.au** or for assistance completing this form call **132 011** Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

Note: Call charges may apply.

Details of person making request

1 Medicare card number

☐☐☐☐ – ☐☐☐☐☐ – ☐ Ref no. ☐

2 Name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

3 Date of birth / /

4 Permanent address

Postcode

5 Postal address (if different to above)

Postcode

6 Daytime phone number

( )

Mobile phone number

Email

@

As we will send your personal information to the email address that you provide, you should be satisfied that the address is appropriate for the receipt of personal information.

Claims information request

7 Indicate the date range(s) for the claims information required.

PBS claims history for the period

From / / to / /

(insert full date range e.g. 01/05/2014 to 31/05/2015)

8 Are you requesting personal or family claims information?

Personal only ☑ ***Go to 14***

Family only ☐

Personal and family ☐

Family members aged 14 years and over

9 Are you requesting information about other family members aged 14 years or over?

No ☐ ***Go to 10***

Yes ☐

Complete question 9 if information is required for other family members aged 14 years and over.

Information requested for family members aged 14 years and over, must be accompanied by their signature.

If the other family members are not listed on your Medicare card they will need to submit a separate request.

Family member 1

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

Date of birth

/ /

Would you like us to send your personal information to a third party?

No ☐

Yes ☐ I authorise the Australian Government Department of Human Services to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

Postcode

Family member 1 signature

Date

/ /

Family member 2

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

Date of birth

/ /

Would you like us to send your personal information to a third party?

No ☐

Yes ☐ I authorise the Australian Government Department of Human Services to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

Postcode

Family member 2 signature

Date

/ /

If the information relates to more than 2 additional family members aged 14 years and over, attach a separate sheet with details.

Requests for children under 14 years of age

A person with parental responsibility can generally get Medicare or PBS information about a child where the child is under 14 years of age and listed on the same Medicare card as the requesting person.

10 Are you requesting information for a child under 14 years of age?

No ☐ ***Go to 14***

Yes ☐

11 Are you the child's parent or guardian?

No ☐ You may not request this claims information

Yes ☐ If legal guardian, attach supporting documents

Child 1

Family name

First given name

Second given name

Other names child known by (if applicable)

Date of birth / /

Is the child a subject of Family Court orders?

No ☐

Yes ☐ Provide a copy of the current court order.

Is the child listed on more than one Medicare card?

No ☐

Yes ☐ Provide details

Child's other Medicare card number

– – Ref no.

Child's other address (if applicable)

Postcode

Child 2

Family name

First given name

Second given name

Other names child known by (if applicable)

Date of birth / /

Is the child a subject of Family Court orders?

No ☐

Yes ☐ Provide a copy of the current court order.

Is the child listed on more than one Medicare card?

No ☐

Yes ☐ Provide details

Child's other Medicare card number

– – Ref no.

Child's other address (if applicable)

Postcode

Child 3

Family name

First given name

Second given name

Other names child known by (if applicable)

Date of birth / /

Is the child a subject of Family Court orders?

No ☐

Yes ☐ Provide a copy of the current court order.

Is the child listed on more than one Medicare card?

No ☐

Yes ☐ Provide details

Child's other Medicare card number

– – Ref no.

Child's other address (if applicable)

Postcode

If the information relates to more than 3 children under 14 years of age, attach a separate sheet with details.

12 Would you like us to send your child's/children's personal information to a third party?

No ☐ ***Go to 14***

Yes ☐

13 I authorise the Australian Government Department of Human Services to provide my child's/children's personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

Postcode

Authorisation

14 Would you like us to send your personal information to a third party?

No ☐ ***Go to 16***

Yes ☑

15 I authorise the Australian Government Department of Human Services to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Zurich Australia Limited

Postal address

GPO Box 4443

SYDNEY NSW Postcode 2001

Privacy notice

16 Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for: the purposes of research, or investigation, or where you have agreed, or where it is required or authorised by law.

If you have requested claims history which is older than 5 years, your personal information will be disclosed to the Department of Health so that your request can be processed.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy** or by requesting a copy from the department.

Declaration

17 **I declare that:**

- I have parental responsibility for each child under 14 years of age for whom I have requested claims information.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Applicant's signature

Date

/ /

Reset form Print form