

### medicare



## Stoma Appliance Scheme application (PB049)

#### When to use this form

Use this form to register your details and show you are eligible to receive products under the Stoma Appliance Scheme (SAS).

Parts 1, 2 and 3 must be completed.

This form must be completed by the following people:

- Part 1: you the applicant or your authorised representative to receive products under the SAS.
- Part 2: your referring medical practitioner or stomal therapy
  pures
- Part 3: the nominated stoma association who is approved to supply products under the SAS.

Forms that are incomplete or cannot easily be read will be returned to your nominated stoma association.

#### For more information

Go to **servicesaustralia.gov.au** or if you need help completing this form, call **1800 700 270** Monday to Friday, 8:30 am to 5 pm, Australian Eastern Standard Time.

Call charges may apply.

Go to **servicesaustralia.gov.au/RHCA** for more information if you are visiting from a country that has a Reciprocal Health Care Agreement with Australia, or if you are a resident of New Zealand or the Republic of Ireland.

# Filling in this form You can complete this form on your computer, print and sign it. If you have a printed form: Use black or blue pen. Print in BLOCK LETTERS. Where you see a box like this Go to 1 skip to the question number shown.

To be completed by the applicant or their authorised

#### PART 1

representative.

Ap	plicant's details
1	Dr Mr Mrs Miss Ms Other
	Family name
	First given name
	Second given name

2	Date of birth
	1 1
3	Address
	Postcode
4	Medicare card number
	Ref no.
	If Medicare card number is not available, the Department of Veterans' Affairs card number
	or
	Reciprocal Medicare card number
	or
	passport number (if a resident of New Zealand or the Republic of Ireland).
5	Do you already have a stoma?
	No 🗔
	Yes Provide SAS Entitlement number:
	Status of new stoma?
	Permanent
	Temporary
	Type of new stoma?
	Colostomy
	lleostomy
	Urostomy
	Other Give details below

Applicant's authorisation		Γ2			
6 Are you completing this form on behalf of the applicant?		To be completed by the <b>referring medical practitioner</b> or <b>stomal therapy nurse</b> only.			
	Rofo	rring medical practitioner or stomal therapy			
·		e details			
To complete this form you must:	Vau	mount provide very provider pumb or or Australian Health			
hold an enduring power of attorney for the applicant		must provide your provider number or Australian Health titioner Regulation Agency (Ahpra) registration number below.			
be an appointed guardian of the applicant, or					
be an Authorised Representative for Medicare purposes     – for more information go to     servicesaustralia.gov.au/authorisedrepresentative		amily name			
Family name		irst given name			
Turniy harno	L				
First siven name	<b>11</b> P	rofessional title			
riist given name					
	<b>12</b> F	Referring practitioner number or Ahpra registration number			
Daytime phone number					
	10 🗈	Practice location			
Email	13 F	Tactice location			
<u></u>					
vacy notice	-	Postcode			
important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to servicesaustralia.gov.au/privacy	е	Vas the patient's current Medicare card or other relevant intitlement card sighted?  No			
plicant's declaration					
I consent to:					
<ul> <li>Medicare collecting, accessing, using, disclosing and recording information about me related to the management of my stoma(s) for the purposes indicated above.</li> </ul>					
I authorise:					
<ul> <li>Medicare to make enquiries about my use of medical or surgical aids, equipment or appliances supplied to me under the Stoma Appliance Scheme.</li> </ul>					
I declare that:					
<ul> <li>the information I have provided on this form is current, complete and correct.</li> </ul>					
I understand that:					
I am required to keep my details up to date with my stoma association.					
· ·					
Applicant's or representative's signature					
	Are you completing this form on behalf of the applicant?  No	Are you completing this form on behalf of the applicant?  No Go to 8  Yes Go to next question  Details of the authorised representative:  To complete this form you must:  • hold an enduring power of attorney for the applicant • be an appointed guardian of the applicant, or • be an Authorised Representative for Medicare purposes — for more information go to servicesaustralia.gov.au/authorisedrepresentative  Family name  Daytime phone number  (( ))  Email  The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to servicesaustralia.gov.au/privacy  plicant's declaration  I consent to:  • Medicare collecting, accessing, using, disclosing and recording information about me related to the management of my stoma(s) for the purposes indicated above.  I authorise:  • Medicare to make enquiries about my use of medical or surgical aids, equipment or appliances supplied to me under the Stoma Appliance Scheme.  I declare that:  • the information I have provided on this form is current, complete and correct.  I understand that:  • I am required to keep my details up to date with my stoma association.  • giving false or misleading information is a serious offence.  Applicant's or representative's signature			

Date

#### **Privacy notice**

15 The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to servicesaustralia.gov.au/privacy

#### **Declaration**

#### 16 I declare that:

- the applicant is eligible to receive products under the Stoma Appliance Scheme as they do not have normal gastrointestinal tract and/or bladder function and have a temporary or permanent artificial body opening (whether surgically created or otherwise) which facilitates the removal of products of the gastrointestinal tract and/or urine.
- the information I have provided in this form is complete and correct.

#### I understand that:

• giving false or misleading information is a serious offence. Referring medical practitioner's or stomal therapy nurse's signature

do					
Date					
	/	/			

#### **Next steps**

- 1 Check Part 1 and Part 2 have been completed, then send to the applicant's nominated stoma association for supply of products.
- 2 They will send onto us at:

Services Australia Stoma Appliance Scheme GPO Box 9826 MELBOURNE VIC 3001

#### PART 3

To be completed by your nominated **stoma association.**Complete the details below or use an association stamp to provide this information.

#### Stoma association's details

17	Stoma association name
18	Stoma association address
	Postcode
19	Stoma association phone number  ( )
20	Stoma association approval number
I	sociation stamp (must include association name, address, one number and approval number)
21	Include the SAS Entitlement Number issued to the patient
De	claration
22	<ul> <li>I declare that:</li> <li>the applicant is eligible to receive products under the Stoma Appliance Scheme.</li> </ul>
	<ul><li>I understand that:</li><li>giving false or misleading information is a serious offence.</li></ul>
	Association representative's signature who has reviewed this form
	<b>L</b> D
	Date