Queensland Government

Patient Travel Subsidy Scheme (PTSS)

APPLICATION FORM

Purpose of the Patient Travel Subsidy Scheme (PTSS)

PTSS provides assistance to patients who need to access essential specialist medical services which are not available within their local area. The PTSS may also provide a subsidy to assist an escort or guardian to accompany the patient.

All applications to, and enquiries about, the PTSS must be forwarded to the patient's nearest public hospital.

Further information about assistance provided under the PTSS is available from any Hospital and Health Service (HHS), Community Health Centre and the PTSS website *http://www.health.qld.gov.au/ptss*

How to apply:

1. A patient is referred by their medical practitioner to a specialist medical service that is not available locally. The patient/guardian or carer completes Section A, and the referring Medical Practitioner completes Section B.
2. Prior to departure, the patient/guardian or escort lodges the application form at their nearest public hospital (the approving hospital). The Medical Superintendent (or delegate) of the approving hospital assesses the application.
3. If the patient is approved, hospital staff will notify the patient/guardian or carer and issue them with a Specialist Confirmation Form for each specialist they will need to see. This form must be completed after treatment by the treating specialist to whom they were referred.. The Specialist Confirmation Form can also be used if the patient is receiving treatment over a longer period of time and needs to make a claim for reimbursement before completion of treatment. In these instances, the patient/guardian or carer should contact staff at their approving hospital to discuss.
4. After treatment is complete, the patient returns home and submits the Specialist Confirmation Form with any receipts or invoices attached.
5. Payment will be made directly to the patient/guardian by Electronic Funds Transfer (or cheque) at the approving hospital's discretion. If the patient/guardian consents, the subsidy may be paid directly to the transport and/or accommodation provider under a bulk-billing arrangement.

SECTION A – PATIENT INFORMATION *(to be completed by the patient or guardian)*

PTSS ID Number:	PTSS Claim Number:	PTSS Application Number:

Title:	Family name:	Given name(s):	DOB: / /
Email address:		Home phone:	
Residential address:		Residential Postcode:	
Postal address (if different):		Mobile phone:	
Have you applied for PTSS within the last financial year (1 July to 30 June)? ☐Yes ☐No		Are you accessing treatment as a private patient or through private health cover? ☐Yes ☐No	

1. Do you hold the following cards:

a) Medicare Card ☐Yes ☐No

Card Number:	Expiry:

b) Health Care Card ☐Yes ☐No

Card Number:	Expiry:

c) Pensioner Concession Card ☐Yes ☐No

Card Number:	Expiry:

d) Commonwealth Seniors Health Card ☐Yes ☐No

Card Number:	Expiry:

e) Dept of Veterans Affairs ☐Gold ☐White ☐Other

Card Number:	Expiry:

2. Indigenous status:

- ☐ Aboriginal but not Torres Strait Islander origin
- ☐ Torres Strait Islander but not Aboriginal origin
- ☐ Both Aboriginal and Torres Strait Islander origin
- ☐ Neither Aboriginal nor Torres Strait Islander origin
- ☐ Not stated/inadequately described

3. Does this application relate to involvement in an accident? ☐Yes ☐No

4. Have you lodged, or do you intend to lodge a Third Party or Workers Compensation Claim relating to this treatment? ☐Yes ☐No

5. Indicate subsidy payment method: ☐ Electronic funds transfer *(preferred method of payment)* ☐ Cheque

6. Patient Declaration:

The information that I have provided is true and accurate at the time of application. I give my permission for HHS staff to obtain information about my medical condition for the purposes of this application; to forward relevant details regarding my application to the treating hospital, transport and/or accommodation provider or other relevant party as is required. I consent for the subsidy to be provided directly to my transport and/or accommodation provider under a bulk-billing arrangement if available. I certify that any subsidies provided to me will be used for the purposes of travelling to access the stated specialist service.

Patient Signature:	**Patient name** *(please print)*:	**Date:** / /
Guardian/Carer Signature:	**Guardian/Carer Name** *(please print)*:	**Date:** / /

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SECTION B – REFERRAL *(to be completed by the referring doctor)*

1. Referral Details:

Reason for referral:	
Specialist referred to:	Specialist address::
Specialty treatment required:	This appointment is for: ☐ Diagnosis ☐ Treatment ☐ Review
Is this the nearest specialist? ☐ Yes ☐ No ►	If No, why?
Is specialist care available via Telehealth? ☐ Yes ☐ No ►	

2. Appointment Details:

Appointment date: / /	Appointment time:

Recommended mode of travel: ☐ Bus ☐ Rail ☐ Air ☐ Private motor vehicle ☐ Other:
Reason for travel mode *(clinical, distance, no other provider)*:
Does the patient have any special travel requirements: eg: wheelchair, oxygen

Does the patient require accommodation ☐ Yes ☐ No	From: / /	To: / /
Reason for accommodation *(clinical, distance, no other provider)*:		

3. Escort Details:

Is an escort required to provide support to the patient? ☐ Yes ☐ No		
If yes, provide **clinical** reason for escort:		
Title:	Family name:	Given name(s):
Relationship to patient:		Phone:

4. Additional Comments:

5. Declaration by Referring Doctor:

I certify that the information in Section B is correct and has been completed by me. I give permission for HHS staff to contact me regarding this referral.

Signature:	Name (please print):	Date: / /
	Provider number:	Phone:

SECTION C – ASSESSMENT & APPROVAL *(to be completed by approving officer – admin use only)*

Is specialist care available via Telehealth? ☐ Yes ☐ No ►	Comments (if any):
Patient/escort satisfies eligibility criteria? ☐ Yes ☐ No ►	
Patient/escort satisfies exception criteria? ☐ Yes ☐ No ►	

☐ **PTSS Approved**:	Approval period: ☐ Single treatment ☐ From: / / to: / /
Patient Travel ☐ Yes ☐ No ► *Comment below*	Patient accommodation ☐ Yes ☐ No ► *Comment below*
Escort Travel ☐ Yes ☐ No ► *Comment below*	Escort accommodation ☐ Yes ☐ No ► *Comment below*
Approved mode of travel: ☐ Bus ☐ Rail ☐ Air ☐ Private motor vehicle ☐ Other:	
Method of payment: ☐ Electronic funds transfer *(provide EFT Form to patient – preferred method of payment)*	☐ Cheque

Name of Medical Superintendent/Delegate: *I authorise this travel/accommodation as medically required*	Signature:	Date: / /
Name of officer with financial delegation: *I authorise expenditure incurred for this application*	Signature:	Date: / /

☐ **PTSS Not Approved** *Provide reasons for non-approval:*