Australian Government
Services Australia

medicare

PBS

Stoma Appliance Scheme application for additional supplies for clinical and other reasons (PB050)

When to use this form

Use this form to apply for additional supplies (for clinical and other reasons) under the Stoma Appliance Scheme (SAS) which are **more than twice** the maximum scheduled quantity per month.

Also use this form to apply for additional products which are **more than 2 month's supply** for holiday issue, members working and living in remote locations and Norfolk Island residents.

Additional supplies can be valid for a period up to **6 months**.

The additional supplies do not include items supplied under a 2 month ordering cycle.

How to fill out this form

This form must be completed by the following people:

- **Part 1**: you - the applicant or your authorised representative.
- **Part 2**: the referring medical practitioner, stomal therapy nurse, or the applicant's nominated stoma association.
- **Part 3**: the referring medical practitioner or stomal therapy nurse.
- **Part 4**: the nominated stoma association.

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

Example 1:

For a clinical supply of 4 times the maximum scheduled quantity, the form should be completed as follows:

The applicant completes Part 1. The applicant's referring medical practitioner or stomal therapy nurse completes Parts 2 and 3 and provides a signed clinical justification certificate for the increased supply. The applicant provides the completed form and supporting justification to their nominated stoma association. The stoma association seeks approval from the Department of Health for the product supply and then completes Part 4 of the form.

Example 2:

For a holiday supply of 6 times the maximum scheduled quantity, the form should be completed as follows:

The applicant completes Part 1. The applicant provides the form to their nominated stoma association to complete Parts 2 and 4. The applicant provides supporting travel documents to the association to verify the increased supply.

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.

PART 1

To be completed by the **applicant** or their **authorised representative**.

Applicant's details

Make sure you keep your details up to date with your nominated stoma association, including your Medicare number.

1 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

2 Date of birth

/ /

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 SAS entitlement number

Applicant's authorisation

6 Are you completing this form on behalf of the applicant?

No ☐ ***Go to 8***

Yes ☐ ***Go to next question***

7 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

First given name

Daytime phone number

( )

Email

Privacy notice

8 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**

Applicant's declaration

9 **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

On completion, print and sign by hand.

Date

/ /

PART 2

To be completed by the **referring medical practitioner** or **stomal therapy nurse**, or the applicant's nominated **stoma association**. Forward this form to the nominated stoma association if required.

Additional supplies requested

10 Select the type of additional supplies required for **more than twice** the maximum scheduled quantity

Clinical ☐ ***Complete Q11 and then go to Part 3***

Remoteness ☐ ***Complete Q11 and then go to Part 3***

Holiday ☐ ***Complete Q11 and then go to Part 4 (stoma association only)***

Norfolk Island resident ☐ ***Complete Q11 and then go to Part 4 (stoma association only)***

11 **Additional product 1** (valid for a period up to 6 months)

Product name

Item code

Manufacturer code

Schedule allowance

Additional quantity required

Commencing date/month/year

/ /

Cessation date/month/year

/ /

Additional product 2 (valid for a period up to 6 months)

Product name

Item code | Manufacturer code

Schedule allowance | Additional quantity required

Commencing date/month/year | Cessation date/month/year

/ / | / /

If more items are required, attach a separate sheet with details.

PART 3

To be completed by the **referring medical practitioner** or **stomal therapy nurse**. You must provide your provider number or Australian Health Practitioner Regulation Agency (Ahpra) registration number.

Referring medical practitioner or stomal therapy nurse details

12 Family name

First given name

13 Professional title

14 Referring practitioner number or Ahpra registration number

15 Practice location

Postcode

16 Type of additional supplies required:

Remoteness ▶ ***Go to next question***

Clinical ▶ tick ALL that apply:

- ☐ Altered physical condition
- ☐ Bilateral stomas
- ☐ Chemotherapy or radiotherapy
- ☐ Fistula and stoma
- ☐ Prolapse
- ☐ Retraction
- ☐ Stenosis
- ☐ Other ▶ Give details below

17 Is the quantity required **more than 4 times** the SAS schedule maximum quantity?

No ▶ ***Go to next question***

Yes ▶ Approval from the Department of Health is required in addition to this completed form.

Signed clinical justification must be provided for additional supplies of more than 4 times the maximum scheduled quantity.

18 Justification for increased quantity

19 Next review date

/ /

20 Was the patient's current Medicare card or other relevant entitlement card sighted?

No ▶ ***Go to next question***

Yes ▶ Make sure the current Medicare number or other relevant entitlement card number is provided in Part 1.

Privacy notice

21 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

22 **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

On completion, print and sign by hand.

Date

/ /

PART 4

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

23 Stoma association name

24 Stoma association address

Postcode

25 Stoma association phone number

( )

26 Stoma association approval number

Association stamp (must include association name, address, phone number and approval number)

For holiday and Norfolk Island additional supply types only

27 Type of additional supplies required:

Holiday ☐ ***Go to next question***

Norfolk Island resident ☐ Confirm applicant's address and ***go to 29***

28 Is the holiday supply **more than 2 times** the SAS schedule maximum quantity?

No ☐ ***Go to 29***

Yes ☐ Make sure you sight supporting travel documents.

Declaration

29 **I declare that**:

- the applicant is eligible to receive products under the Stoma Appliance Scheme.

I understand that:

- giving false or misleading information is a serious offence.

Association representative's signature who has reviewed this form

On completion, print and sign by hand.

Date

/ /

Reset form Print form

Next steps

1 Check all required parts are completed.
2 Send the completed form and any supporting documents to:

Services Australia
Stoma Appliance Scheme
GPO Box 9826
MELBOURNE VIC 3001