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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Travel Subsidy Scheme (PTSS)    Patient registration (Form A) | | | | | | | | | | |
| **Section A (patient or guardian / carer to complete)** | | | | | | | | | | |
| Updating existing patient details | | | | | | | | | | |
| Title: | Given name(s): | | | | | Family name: | | | | |
| Preferred name: | | | | | | | | Date of birth (DD/MM/YYYY): | | |
| Residential address: | | | | Suburb / Town: | | | | | | Postcode: |
| Postal address (if different from residential address): | | | | Suburb / Town: | | | | | | Postcode: |
| Mobile number (or landline, if mobile not available): | | | Email address: | | | | | | | |
| Are you of Aboriginal and / or Torres Strait Islander origin?  No  Yes, Aboriginal  Yes, Torres Strait Islander  Yes, both Aboriginal and Torres Strait Islander | | | | | | | | | | |
| Preferred contact person (if different from patient): | | | | | Relationship: | | | | | |
| Mobile number (or landline, if mobile not available): | | | Email address: | | | | | | | |
| How would you like us to contact you? (You may select more than one option) Text message  Email  Phone  Mail | | | | | | | | | | |
|  | | | | | | | | | | |
| **Section B (patient or guardian / carer to complete)** | | | | | | | | | | |
| * A Medicare card number is required to be eligible for PTSS. | | | | | | | | | | |
| Medicare number: | | | | | | | Expiry date (MM/YY): | | | |
| **Please tick if any of the following apply to you:** | | | | | | | | | | |
| Department of Veterans Affairs | | Card number: | | | | | Expiry date (DD/MM/YY): | | Card type (e.g. gold): | |
| Healthcare card | | Card number: | | | | | Expiry date (DD/MM/YY): | | | |
| Pensioner concession card | | Card number: | | | | | Expiry date (DD/MM/YY): | | | |
| Commonwealth Seniors card | | Card number: | | | | | Expiry date (DD/MM/YY): | | | |
|  | | | | | | | | | | |
| **Section C (patient or guardian / carer to complete)** | | | | | | | | | | |
| *The information provided is true and accurate at the time of application. I give my permission for Hospital and Health Service*  *staff to obtain information about my / my child's / my ward's medical condition for the purpose of administering my application*  *and to disclose relevant information, including a copy of this form, to approved travel / accommodation providers for the*  *purpose of administration of the Patient Travel Subsidy Scheme (PTSS). I understand that I must keep copies of receipts /*  *invoices for accommodation and transport, and may be asked to provide these to Hospital and Health Service staff.* | | | | | | | | | | |
| Patient (if 18 years or over) or Guardian / Carer (if under 18 years) signature: | | | | | | | | Date (DD/MM/YYYY): | | |
| Guardian / Carer name: | | | | | | | | Contact number: | | |
|  | | | | | | | | | | |
| **Hospital and Health Service use only** | | | | | | | | | | |
| Identification number: | | | | | | | | | | |
| Proof of residency sighted / provided (e.g. QLD licence, electricity / gas bill, other acceptable documents)?  Yes  No  Concession card(s) sighted / provided?  Yes  No | | | | | | | | | | |
| **Sighted by** – staff name: | | | Signature: | | | | | Date (DD/MM/YYYY): | | |