AUSTRALIAN HEALTH SERVICE ALLIANCE
REQUEST FOR PAYMENT OF NON-PROSTHESES LIST ITEMS

Guidelines for completion / application

This form is to be used when requesting payment for a medical device not listed on the Ministerially approved Prostheses List and is to be used to request consideration for funding of items for specific patients. Please be aware that some items that are not on the prostheses list may be covered under other funding arrangements such as HPPA's and theatre bands and therefore not eligible for additional payment.

For payment to be considered by the fund, all areas of the form must be completed in legible writing, and additional information requested below supplied.

Please forward this submission directly to the health fund concerned with as much notice as possible prior to the operation date as the health fund may not agree to contribute after the procedure. Please supply the following information along with this form:

- A letter from the doctor outlining patient's age, relevant medical conditions, reasons for choice, alternatives and expected outcome (i.e. clinical indicators).
- IPU (Individual Patient Usage) certificate where required (or notification that this is being sought) or TGA Approval. Whilst a fund may in principle approve a request where an IPU certificate is being sought, final approval will not be given until a copy of the IPU is forwarded to the fund.
- Relevant product information including information from suppliers outlining comparators.

Date of Request: ..... **Date of Procedure:** .....

Member Details:

Member/Patient Name:	
Member Date of Birth:	
Health Fund:	
Fund Membership Number:	

Hospital Details:

Hospital/Facility Name:	
Treating Doctor's Name:	
Doctor's Phone Number:	

Item Details:

Item Description:			
Model No:		TGA/IPU Approved	❑ YES / ❑ NO

Supplier:			
Supplier Contact Name:			
Supplier Phone Number:			
Intended Charge:			
Procedure MBS No:		Theatre Band:	
DRG (EPM hospitals)			
Quantity of Items Likely to be Used:			
Comparator Items/Code/Charge:			

Procedure Details:

What are the clinical indications for requesting funding of a non-prostheses list item?
Provide brief explanation of Procedure:
What are the alternatives?
Could a currently listed item be used for this procedure? ❑ YES - *Please give details below* ❑ NO
Why is this item indicated in preference to a listed Prostheses Item? *(What clinical outcome benefits do you expect, which are not provided by the currently listed items?)*
Expected Clinical Outcomes?
What is the outcome to the member if the Fund doesn't approve your request?
Other Comments:

Signature: _____ **Date:** _____

To be completed by Health Fund:

Fund Contact Name & Title:	
Fund Approval / Denial:	❑ Approved ❑ Denied

Fund Signature: _____ **Date:** _____