Australian Government
Department of Health

Claim for Payment
Tax Invoice
Office of Hearing Services

Supplier - Service Provider Name

Client details

Voucher number | Family name | Initials

Claim details

Only complete this section if claiming non-fitting items

Qty	Item Number	Date of Service (ddmmyy)	Site ID	Practitioner Number	Item benefit (exclusive of GST)	GST amount	Total benefit (inclusive of GST)
					$	$	$
					$	$	$

Only complete this section if claiming a fitting item – only one fitting item per claim form.

Qty	Item Number	Date of Service (ddmmyy)	Site ID	Practitioner Number	Item benefit (exclusive of GST)	GST amount	Total benefit (inclusive of GST)
					$	$	$
Ear	Device Code	Date of Fitting (ddmmyy)	Cost to Client (nil if no cost)	Top up Device (Alternative Category)	Device benefit (exclusive of GST)	GST amount	Total benefit (inclusive of GST)
L					$	$	$
R					$	$	$
Total cost of fitting item and devices only. (do not include non-fitting items)					$	$	$

Clinical Details

For Item 670 Rehabilitation service only

(must be within range of 1 to 120dB)

Date of follow-up

3FAHL **Left** | **Right**

Certification by Client	
(You should not sign a claim form that is blank or incomplete. You are entitled to take away a copy of the completed claim form for your records.)	
I certify that I have received the service(s) and / or device(s) listed above:	Yes ☐ No ☐
I have made / will make a payment to the provider for hearing aid maintenance services:	Yes ☐ No ☐
If YES, amount of maintenance fee paid / to be paid to provider: (GST inclusive)	$
I am still eligible to receive full services under the Australian Government Hearing Services Program:	Yes ☐ No ☐
I understand that information provided on this form is required for the delivery of services under the *Hearing Services Administration Act 1997* and will be supplied to Medicare and the Office of Hearing Services.	

Name | Signature | Date

Certification by Service Provider (There are penalties for giving false or misleading information).

I certify that I have fully informed the client about the free hearing services and devices available to them, the details on this claim form are true and that a fee for the service(s) and/or device(s) has not been previously claimed.

Total Cost of program to the client $ | Are you income tax exempt? Yes ☐ No ☐

Service Provider Number | Are you GST registered? Yes ☐ No ☐

ABN Number | ABN Branch extension

Print Name of authorised person | Signature of Authorised person | Date

Customer: Office of Hearing Services Australian Government Department of Health **ABN:** 83 605 426 759