Australian Government
Department of Human Services

medicare

Voluntary acknowledgement of incorrect payments

Purpose of this form

Use this form if you want to notify the Australian Government Department of Human Services if you are prepared to repay benefits incorrectly paid under Medicare or the Child Dental Benefits Schedules.

The *Health Insurance Act 1973* and the *Dental Benefits Act 2008* enables recovery of a debt where Medicare Benefits or Child Dental Benefits Schedule items have been paid due to a false or misleading statement. The debt is recoverable from the person who made the statement. Submitting an incorrect bulk bill claim or issuing an incorrect receipt is a false or misleading statement under the above legislation.

For Medicare Benefits Schedule items only, the *Health Insurance Act 1973* also imposes a 20 per cent penalty for debts over $2,500, which may be reduced if you voluntarily acknowledge a debt using this form.

For more information

For more information about penalties, go to our website **humanservices.gov.au/hpaudits > managing**

Filling in this form

- **Please use black or blue pen**
- Print in BLOCK LETTERS
- Mark boxes like this ☐ with a ✓ or ✗

Returning your form

Check that you have answered all the questions you need to answer and that you have signed and dated this form.

Send the completed form and attachments to:

Department of Human Services
Debt, Appeals and Health Compliance Division
Voluntary Compliance Team
PO Box 7788
CANBERRA BC ACT 2610

or

scan the completed form, and email to **voluntary.compliance.team@humanservices.gov.au**

Please do not send any cheques or cash with this form.
We will contact you to confirm the amount owing.

Provider details

1 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Second given name

2 Medicare provider number

3 Provide the following details if you wish to be contacted at an address or phone number that is different to those held by the Department of Human Services for Medicare claiming purposes.

Address

Postcode

Daytime phone number (   )

Mobile phone number

Fax number (   )

Email

@

4 Audit reference number (if applicable)

Privacy notice

5 Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy** or by requesting a copy from the department.

Declaration

The Australian Government Department of Human Services will acknowledge the receipt of this form.

6 **I declare that:**

- I am the health professional who rendered the services listed in this form.
- the information I have provided in this form, including the schedule of services, is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Provider's signature

✍

Date

/ /

7 Provide details of services relevant to your voluntary acknowledgement

Patient family name	**Patient given name(s)**	**Patient date of birth**	**Patient Medicare card number**	**Date of service**	**Item number claimed**	**Comments (e.g. claimed incorrectly, service not provided)**
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If you require more space, attach a separate sheet with details.

Reset form **Print form**