2.3 Medical Travel

If not available through PATS or other providers, this program assists members with travel expenses for medical care away from home, medical escorts, patient support travel, and support for critically ill or injured IBN members and their children.

Please tick the box that describes the assistance you are requesting:

- ☐ IBN patient travel
- ☐ Medical Travel Escort
- ☐ Patient support for an ill or injured child
- ☐ Patient support for critically-ill or critically-injured person

Need help with this form? Freecall **1800 014 401**

Returning this form
Email: applications@ibngroup.com.au
Post: PO Box 2390, South Hedland, WA, 6722
Fax: (08) 9140 0998
In person: 3 Brand Street, South Hedland
973 Central Road, Tom Price
Unit 3, 4 Welcome Road Karratha

Benefits, exclusions and conditions
Refer to the Community Programs Handbook or visit ibngroup.com.au

Required documentation
See 'Attachments' check box. Applications cannot be processed until all required documentation is provided.

Processing time
3-5 working days once all required documentation is received.

IBN Community Member applying for assistance

1 Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐
Snr ☐ Jnr ☐

First given name

Second given name

Last name

2 Have you been known by any other name?
No ☐
Yes ☐ Provide name

3 Your date of birth
/ /

4 Your gender
Male ☐ Female ☐

5 Language group
Yinhawangka ☐ Banyjima ☐ Nyiyaparli ☐

6 Mobile phone number
(to be used to advise you of the progress of your application)

7 Email address

8 Current home address

Postcode

9 Is your current address the same address you registered with IBN?
No ☐ You will need to complete an 'Update personal details form' and attach it to this application.
Yes ☐

10 Have you received financial assistance from any other trust(s) in the past three months?
No ☐
Yes ☐ Name of organisation

Amount
$

11 Have you applied for assistance from PATS or other sources?
No ☐ Applicants must first apply to PATS, private health insurance, workers compensation or other trusts before applying to IBN for assistance.
Yes ☐ Amount approved?

Who are you seeking assistance for?

12 Are you applying for assistance for yourself?
No ☐ Go to question 13
Yes ☐ Go to question 14

13 You **must** be a legally responsible parent, adoptive parent or guardian of the dependent child/children you are seeking assistance for.

Are you applying for assistance for a dependent child/children legally in your care?
No ☐ You cannot apply for assistance for a child/children not legally in your care.
Yes ☐ How many children?

Please complete relevant section below

14

IBN Patient Travel:

Name of patient traveling?

Medical Travel Escort:

Name of escort(s)

Patient Support for ill or injured child:

Name of ill or injured child

Name of parent or guardian accompanying the child

Patient Support of Critically-ill or Critically-injured person:

Name(s) of patient supporters

Assistance requested

15

Expense 1

Name of supplier to be paid | Amount required ($)

Expense 2

Name of supplier to be paid | Amount required ($)

Expense 3

Name of supplier to be paid | Amount required ($)

Expense 4

Name of supplier to be paid | Amount required ($)

Expense 5

Name of supplier to be paid | Amount required ($)

Attachments

16

To enable IBN to assess your application quickly and accurately you must provide the following documents when submitting your application.

- ☐ All medical travel requires a copy of a referral and doctor's appointment letter
- ☐ Copy of private health and/or travel insurance cover
- ☐ Evidence that PATS, private health or travel insurance rebate, or other relevant assistance has been sought and the amount approved
- ☐ Supplier quotes/invoices including payment details must be sent directly by the supplier to IBN
- ☐ To extend accommodation beyond three nights, medical confirmation is required from a doctor, nurse practitioner or hospital social worker.

Dependent child/children

- ☐ Dependent Child Advice form *(if relevant)*

Declaration

17 I declare that:

- the information I have provided in this form is true and correct.
- the assistance requested is for my own use or for the use of a dependent child/children legally in my care.

I agree to:

- my information being shared with or checked by other organisations for application assessment purposes.

Signature

Date

/ /

Office use only

Date received / / CP#

Received by

IBN Corporation Pty Ltd | ACN 093 140 240