Medicare Ineligible and Reciprocal Health Care Agreement

Summary This Policy Directive provides policy determinations and other information relevant to charging overseas visitors, temporary residents and Medicare Ineligible persons for services provided by NSW Health public hospitals and facilities. It will enable staff to easily establish the correct classification of overseas visitors, temporary residents and Medicare Ineligible persons when accessing services provided by NSW Health public hospitals and facilities.

Document type Policy Directive

Document number PD2021_021

Publication date 30 June 2021

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Replaces PD2016_055

Review date 30 June 2026

Policy manual Not applicable

File number H21/122522

Status Active

Functional group Corporate Administration - Fees

Applies to Public Health Units, Local Health Districts, Board Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, NSW Health Pathology, Cancer Institute, NSW Ambulance Service, Public Hospitals

Distributed to Ministry of Health, Public Health System, NSW Ambulance Service

Audience Hospital Administration;Administration and Clinical Staff;Administration;Directors of Finance;Administrative, Directors of Finance, Revenue Managers, Billing Staff Administration;Hospital Executives

Secretary, NSW Health

MEDICARE INELIGIBLE AND RECIPROCAL HEALTH CARE AGREEMENT

POLICY STATEMENT

NSW Health charges Medicare Ineligible patients for services received at NSW Hospitals - unless they are exempted. Enables correct classification and relevant information for charging overseas visitors, temporary resident and Medicare ineligible persons when accessing health services.

SUMMARY OF POLICY REQUIREMENTS

All persons presenting to an emergency department with an urgent clinical condition must be assessed and provided with treatment clinically required at that time.

Patients that are overseas visitors, temporary residents and Medicare ineligible in accordance with this Policy Directive must:

1. Be assessed for eligibility for medically necessary treatment at no charge or charges at the appropriate rate.
2. Ensure the ability of NSW Health to fund the treatment of overseas patients does not interfere with the physical, clinical and / or financial capacity of any health service to meet clinical priorities for Australian residents.

REVISION HISTORY

Version	Approved by	Amendment notes
June-2021 (PD2021_021)	Deputy Secretary, Finance	Changes to Guarantor wording
November 2016 (PD2016_055)	Deputy Secretary, Finance	Change to Student Visa numbers, pharmacy charges for inpatients, charging for HIV and HEP B&C Patients
July 2016 (PD2016_031)	Deputy Secretary, Finance	Amalgamation of PD2005_045, PD2005_411, PD2005_508, PD2009_068
October 2009 (PD2009_068)	Director General, Health NSW	New Policy

ATTACHMENTS

1. Medicare Ineligible and Reciprocal Health Care Agreement: Procedures

CONTENTS

1 BACKGROUND

1.1 About this document

This document has been created to provide a consolidated reference document of policy determinations and other information relevant to charging overseas visitors, temporary residents and Medicare Ineligible persons for services provided by NSW Health public hospitals and facilities

Enable staff to easily establish the correct classification of overseas visitors, temporary residents and Medicare Ineligible persons when accessing services provided by NSW Health public hospitals and facilities.

1.2 Key principles

1. All persons presenting to an emergency department with an urgent clinical condition should be assessed and provided with treatment clinically required at that time.
2. Ensure the ability of NSW Health to fund the treatment of overseas patients does not interfere with the physical, clinical and / or financial capacity of any health service to meet clinical priorities for Australian residents.
3. This policy **does not** apply to the following categories of Medicare eligible people:
    a. Australian citizens
    b. Holders of permanent residence visas
    c. Persons applying for a permanent resident visa who have a parent, spouse or child who is an Australian citizen or has the right to stay in Australia permanently
    d. New Zealand citizens who have left NZ and are now living in Australia
    e. Diplomats and their families from a country with a Reciprocal Health Care agreement (RHCA) – other than Belgium, New Zealand, Norway and Slovenia.

NOTE: All the above classifications should present a valid Medicare card to confirm eligibility. If no Medicare card is presented the patient should be presumed ineligible until such time as a card is presented.

4. All persons **not** in one of the above categories are Medicare Ineligible. In accordance with this policy directive they must be:
    a. Assessed for eligibility for medically necessary treatment at no charge or
    b. Charged at the appropriate rate.

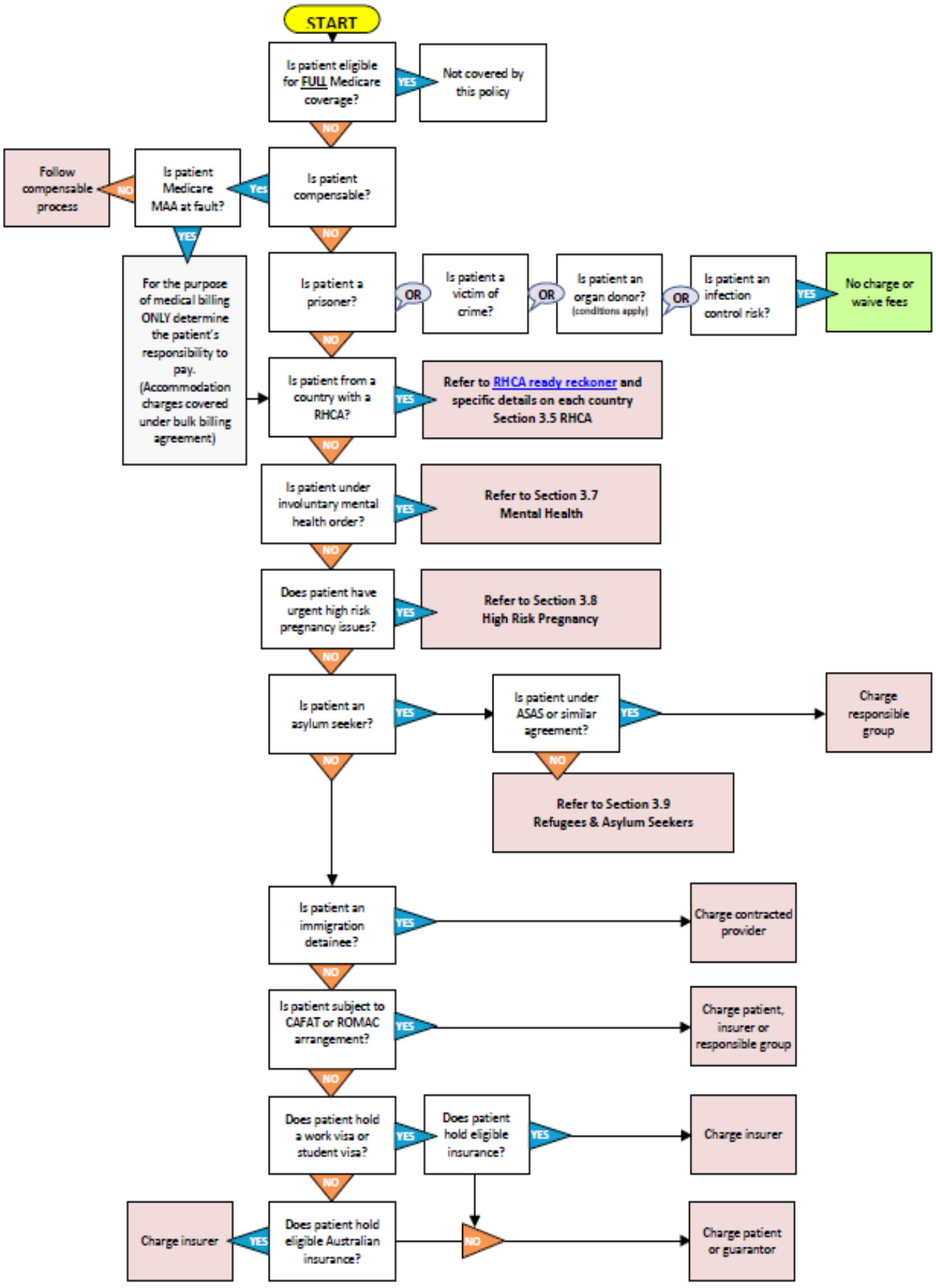
Where required, interpreters and family or community support should be utilised to ensure all the necessary information is captured to determine the patient's status.

The flow chart in section 2.3 and detailed policy in section 3 guides this assessment and determination.

2 QUICK REFERENCE FLOW CHART

Quick Reference Flow Chart

This Policy Directive introduces a simplified approach to classification and charging of Medicare Ineligible persons.


START
Is patient eligible for FULL Medicare coverage?
YES
Not covered by this policy
NO
Is patient compensable?
Yes
Is patient Medicare MAA at fault?
NO
Follow compensable process
YES
For the purpose of medical billing ONLY determine the patient's responsibility to pay. (Accommodation charges covered under bulk billing agreement)
NO
Is patient a prisoner?
OR
Is patient a victim of crime?
OR
Is patient an organ donor? (conditions apply)
OR
Is patient an infection control risk?
YES
No charge or waive fees
NO
Is patient from a country with a RHCA?
YES
Refer to RHCA ready reckoner and specific details on each country Section 3.5 RHCA
NO
Is patient under involuntary mental health order?
YES
Refer to Section 3.7 Mental Health
NO
Does patient have urgent high risk pregnancy issues?
YES
Refer to Section 3.8 High Risk Pregnancy
NO
Is patient an asylum seeker?
YES
Is patient under ASAS or similar agreement?
YES
Charge responsible group
NO
Refer to Section 3.9 Refugees & Asylum Seekers
NO
Is patient an immigration detainee?
YES
Charge contracted provider
NO
Is patient subject to CAFAT or ROMAC arrangement?
YES
Charge patient, insurer or responsible group
NO
Does patient hold a work visa or student visa?
YES
Does patient hold eligible insurance?
YES
Charge insurer
NO
Does patient hold eligible Australian insurance?
YES
Charge insurer
NO
Charge patient or guarantor

3 PATIENT CLASSIFICATION

3.1 Compensable Patients

All compensable patients including overseas visitors and temporary Australian residents who meet the criteria for coverage by a compensable insurer or employer must be classified under the appropriate financial classification and normal charging arrangements for compensable patients applied. The categories this applies to are:

- NSW motor vehicle accidents - Motor Accident Authority (MAA) and the Lifetime Care Support scheme (LTCS)
- Workers compensation - employer or insurer
- Third party insurer - public liability claim in place, or interstate motor vehicle accident (MVA).

Process

Using the patient interview and admission election/declaration form, ensure:

- All patient details are captured
- Alternative election and / or payment details in the event that the compensable claim is rejected

3.1.1 NSW Motor Accident Authority - MAA at Fault

For Medical Billing purposes only, the driver / rider at fault is not considered a compensable patient and must make an alternative election according to eligibility: Reciprocal Health Care Agreement (RHCA), Medicare Ineligible, Private, Public, Department of Veterans Affairs (DVA).

For accommodation purposes the patient is covered under the bulk billing arrangement.

Process

Collect medical billing payment up front or ensure guarantee of payment.

3.2 Prisoner

All prisoners, including overseas visitors and temporary Australian residents, are entitled to free medically necessary inpatient and non-inpatient services provided by NSW public hospitals. For full fees policy on prisoners, refer to NSW Health Policy Directive *Health Services Act 1997 - Scale of Fees for Hospital and other Health Services* (PD2020_025).

Note: For immigration detainees see section 3.10

3.3 Victim of Crime

Where an overseas visitor or temporary Australian resident presents at a NSW public health service as a victim of crime for inpatient or non-inpatient treatment they are to be classified according to the following:

- If the police are in attendance or have supplied an event number, which confirms that the person is a victim of crime, then treatment is to be provided by a hospital nominated doctor and the patient is to be classified as Medicare Ineligible, but no hospital / medical charges are to be raised.
- In all other instances the patient is classified and charged in accordance with this document, e.g. RHCA, Overseas Visitor, etc.

3.4 Organ Donor

Once the determination has been made, following appropriate policy, that a *brain-dead patient* is a potential donor the potential donor should be classified as non- chargeable.

Live donation

When a suitable foreign donor has been accepted for a live transplant for a Medicare eligible Australian resident they are to be classified as a non-chargeable Medicare ineligible donor for all medical treatment related to the donation.

3.5 Reciprocal Health Care Agreements (RHCA)

Reciprocal health care agreements have been negotiated between the Commonwealth of Australia and eleven other countries. These agreements govern access to free or subsidised health care for each country's residents when in the other country.

A ready reckoner has been developed and is available here (Appendix C) Countries that have a RHCA with Australia are:

RHCA Countries with Australia		
Belgium	Finland	Republic of Ireland
Italy	Malta	Netherlands
New Zealand	Norway	Slovenia
Sweden	United Kingdom (Inc England, Scotland, Wales, Northern Ireland, Channel Isles: Jersey and Guernsey.	

To be eligible for free or subsidised treatment under a RHCA:

- The person must meet the eligibility requirements specified in the RHCA with their country.
- The treatment must be *medically necessary* at that time.
- The patient must be classified as a public patient in a public hospital or as a public outpatient.

This does **not mean** that all assessment, treatment and ongoing care must be provided by a public health organisation**.**

With the exception of residents of New Zealand or the Republic of Ireland, people covered by a RHCA can enrol for Medicare and access alternatives for primary and ambulatory medical care. They are able to:

- Access Medicare benefits when consulting a GP or referred to a Specialist in private practice, including diagnostics
- Access prescription pharmacy items dispensed under the Pharmaceutical Benefits Scheme (PBS).

If, after the initial clinical assessment, further diagnosis and/or care could be managed by a professional in the private sector, the patient can be advised and referred to a private sector provider.

Privately insured - RHCA

People who are eligible residents of RHCA countries are entitled to elect to be treated as a private inpatient in NSW public hospitals for medically necessary and non-medically necessary treatment however, they will not be able to claim Medicare benefits to cover medical and diagnostic service charges.

It is important that eligibility checks are completed with insurers in order to fully inform the patient of their financial obligations prior to treatment.

Dialysis - RHCA

Acute dialysis required as part of the treatment of an urgent medical condition is part of medically necessary treatment under the RHCA.

Maintenance renal dialysis is not covered by the agreements with Malta, Italy, Finland and Norway.

Maintenance renal dialysis may be made available free of charge to other RHCA eligible visitors to Australia, but this will depend on the availability of resources in the treating hospital.

Conditions:

- Arrangements directly between the overseas health authority and NSW health services must be made in advance of arriving in NSW and agreed to by the service provider's General Manager or equivalent delegation level
- No more than 10 treatments are required during one visit to Australia.

Where arrangements are not made in advance or the number of treatments exceeds 10 services, treatment are to be charged at the ineligible dialysis rate. For full fees policy and rates for ineligible dialysis, refer to NSW Health Policy Directive *Health Services Act 1997 – Scale of Fees for Hospital and Other Services* (PD2020_025).

Magnetic Resonance Imaging (MRI)

Where the patient holds a Medicare card and a physician provides a referral indicating the MRI is required as a matter of urgency, Medicare will cover outpatient MRI services.

Visitors who do not hold a valid Medicare card are not covered for outpatient MRI services and charges must be raised to these patients at the AMA rate.

Medically Necessary Definition

Medically necessary refers to assessment, diagnosis and treatment of an injury, sickness or other health condition that is clinically required during the RHCA patient's stay in Australia. It may include investigation, follow-up and stabilisation needed to enable the person to return to their home country.

The following categories of services are considered to be medically necessary:

- Emergency department assessment and treatment where the assessment and treatment cannot reasonably be referred to an appropriate professional who is able to accept new patients that day or on the next business day
- Clinically required acute admission as a public patient to a:
    - Public hospital
    - Public mental health service.
- Admission for a non-elective booked procedure where the patient is placed on a hospital booking system and the urgency category for that booking meets the same clinical criteria as for a Medicare eligible patient
- Ambulatory care, mental health services and other community health services where the assessment and treatment cannot be referred to an appropriate professional who is able to accept new patients with a time frame equivalent to that experienced by Medicare eligible patients
- Outpatient clinic attendances referred by an ED clinician or community health staff where the assessment and treatment cannot reasonably be referred to an appropriate professional within a time frame equivalent to that experienced by permanent Australian residents
- Antenatal, confinement and postnatal services equivalent to that provided to Medicare eligible patients in the public health system
- Inter-hospital patient transport required for continuing care.

Not covered by RHCA

RHCAs do not cover a range of health-related services or other services arising from a health condition. In addition to not covering treatment that is not "medically necessary" as outlined above, RHCAs do not cover:

- Costs of primary ambulance services (from accident or emergency to hospital)
- Treatment that has been pre-arranged before arrival in Australia with the exception of limited dialysis
- Funerals
- Medical repatriation costs for return home or transfer to another country.

3.5.1 Belgium

Visitors and visas not mentioned below

Patient is eligible for medically necessary treatment as long as they can show a current:

- Yellow (RHC) Medicare card or
- Belgium passport and a valid European Union health insurance card.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient is eligible for medically necessary treatment under the RHCA as long as they can show a current Belgium passport and a valid European Union health insurance card.

Patient are to apply for and hold a current Yellow (RHC) Medicare card but this is not mandatory.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is **not** eligible to be covered by the Reciprocal Health Care Agreement and must be treated as an ineligible patient.

3.5.2 Finland

Visitors and visas not mentioned below

Maintenance dialysis is **not** covered by the agreement

Patient is eligible for other medically necessary treatment as long as they can show a current:

- Yellow (RHC) Medicare card or
- Passport issued by Finland.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. Patient must confirm their eligibility and supply evidence to the health service. Patient will not be able to claim Medicare rebates and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is eligible for **full** Medicare coverage.

Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.3 Republic of Ireland - Visitors and visas not mentioned below

Patient is eligible for medically necessary treatment as long as they can show a current passport issued by the Republic of Ireland.

Temporary visitors from the Republic of Ireland are **not** eligible for a Reciprocal Health Care Medicare card and only entitled to medically necessary treatment as an inpatient or outpatient of a public hospital.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance, it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420, 457 & 485 – Temporary work

Patient is covered by the RHCA.

Visa subclass 485 – Temporary graduate

Patient is covered by the RHCA.

Visa subclass 405 or 410 – Retirement

Patient is not covered by the agreement and must maintain adequate health insurance or personally meet all costs as an ineligible patient.

Diplomat

Patient is eligible for **full** Medicare coverage.

Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.4 Italy

Visitors and visas not mentioned below

Patient is eligible for medically necessary treatment as long as they can show a current:

- Yellow (RHC) Medicare card or

- A current passport indicating the patient is a **citizen** of Italy and date of entry to the country is less than 6 months prior to date of treatment.

Maintenance dialysis is **not** covered by the agreement.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance, it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment for services provided otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is eligible for **full** Medicare coverage.

Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.5 Malta

Visitors and visas not mentioned below

Patient is eligible for medically necessary treatment as long as they can show a current:

- Yellow (RHC) Medicare card or
- Passport indicating the patient is a citizen of Malta and date of entry to the country is less than 6 months prior to date of treatment.

Maintenance dialysis is **not** covered by the agreement.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance, it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590– Student and dependant

Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is eligible for **full** Medicare coverage.

Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.6 Netherlands

Visitors and visas not mentioned below

Patient is eligible for medically necessary treatment as long as they can show a current:

- Yellow (RHC) Medicare card,
- Passport issued by The Netherlands and a valid European Union health insurance card.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance, it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient is eligible under the RHCA.

Patient are to apply for and hold a current Yellow (RHC) Medicare card but this is not mandatory.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible Visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is eligible for **full** Medicare coverage.

Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.7 New Zealand

Temporary visitors

Temporary visitors from New Zealand must hold:

- A current New Zealand passport or
- Any other current passport or current certificate of identity endorsed to the effect that the holder is entitled to reside in New Zealand indefinitely or
- A current refugee travel document granted by the Government of New Zealand.

Temporary visitors from New Zealand are **not** eligible for a Reciprocal Health Care Medicare card and are only entitled to medically necessary treatment as an inpatient or outpatient of a public hospital.

Temporary visitors from New Zealand are eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance, it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Permanent residents of Australia

New Zealand citizens with permanent resident status in Australia are eligible for full Medicare coverage and must present a current Medicare card.

Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

Visa subclasses are not applicable

The Trans-Tasman Travel Arrangement allows Australian and New Zealand citizens to live, work and study in each other's country without restrictions and no applicable sub-classes apply.

Diplomat

Patient is **not** eligible to be covered by the Reciprocal Health Care Agreement and must be treated as an ineligible patient.

3.5.8 Norway

Visitors and visas not mentioned below

Maintenance dialysis is **not** covered by the agreement

Patient is eligible for other medically necessary treatment as long as they can show a current:

- Yellow (RHC) Medicare card or
- Passport issued by Norway.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is **not** eligible to be covered by the Reciprocal Health Care Agreement and must be treated as an ineligible patient.

3.5.9 Slovenia

Visitors and visas not mentioned below

Patient is eligible for medically necessary treatment as long as they can show a current:

- Yellow (RHC) Medicare card or
- Passport issued by Slovenia and a valid European Union health insurance card.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance, it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient is eligible under the RHCA.

Patient should apply for and hold a current Yellow (RHC) Medicare card but this is not mandatory.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is **not** eligible to be covered by the Reciprocal Health Care Agreement and must be treated as an ineligible patient.

3.5.10 Sweden

Visitors and visas not mentioned below

Patient is eligible for medically necessary treatment as long as they can show a current:

- Yellow (RHC) Medicare card or
- Swedish passport.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance, it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient maintains cover through the Swedish National Board of Student Aid (CSN International) then patient is covered by the Reciprocal Health Agreement and must apply for and hold a current Yellow (RHC) Medicare card (this is not mandatory).

If patient does not hold cover with CSN then patient is not eligible under the RHCA and must maintain adequate Overseas Student Health Cover or meet the costs as an ineligible visa holder.

Visa subclass 401, 403, 416, 420 or 457 – Temporary work

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 485 – Temporary graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is eligible for **full** Medicare coverage.

Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.5.11 United Kingdom

Visitors and visas not mentioned below

Patient is eligible for medically necessary treatment as long as they can show a current:

- Yellow Reciprocal Health Care Medicare card or,
- Passport issued by the United Kingdom:
  - England
  - Scotland
  - Wales
  - Northern Ireland
  - Isle of Man
  - Channel Isles:
    - Jersey,
    - Guernsey.

United Kingdom citizens only retain eligibility under the RHCA for a period of up to five years after permanently leaving the United Kingdom, following that time they are to be treated as ineligible unless they have become Medicare eligible.

Patient is eligible to choose to be a privately insured or self-paying patient for any treatment, including non-medically necessary. If patient intends to use their travel or health insurance, it is important that the patient confirms their eligibility and supplies evidence to the health service. Patient will not be able to claim Medicare rebates for medical and diagnostic treatments and charges will be raised at the ineligible rate.

Visa subclass 500, 570, 571, 572, 573, 574, 575, 576, 580 or 590 – Student and dependant

Patient is eligible under the RHCA.

Patient should apply for and hold a current Yellow (RHC) Medicare card but this is not mandatory.

Visa subclass 401, 403, 416, 420 or 457 & 485 – Temporary work and graduate

Patient must hold a current Yellow (RHC) Medicare card to access medically necessary treatment otherwise they must maintain adequate health insurance to meet the cost of all health services.

If neither of the above conditions is met the patient must be charged at the ineligible Visa rate. The patient may receive a refund of this charge if they obtain a Medicare card that is valid for the date of service.

Visa subclass 405 or 410 – Retirement

Patient must hold a Yellow (RHC) Medicare card to access medically necessary treatment. Once the card has expired patient is **not** covered by the RHCA and is considered to be ineligible for access to free services and required to meet the cost of all health services.

Diplomat

Patient is eligible for **full** Medicare coverage.

Patient is eligible to choose to be treated as a Private patient with full Medicare rebates applied.

3.6 Infection control and public health containment

To enhance patient compliance and control of certain infectious diseases, with the exceptions of the specifics on charging below, the following will be supplied free of charge.

- Screening, treatment and post-exposure prophylaxis specifically for:
    - Tuberculosis (TB)
    - Leprosy
    - Other notifiable conditions subject to public health unit investigation and control such as but not limited to hepatitis A, measles, meningococcal disease, whooping cough, typhoid and rabies.
- Infection control treatments prescribed subsequent to attendance at a Sexual Assault Service.
- Immunisation of children in accordance with the NSW immunisation schedule.

Due to the emergence of threats to public health, the specific public health conditions may vary in accordance with directions from the Chief Health Officer, Health Protection NSW or local health district public health unit directors.

Charges apply to:

Onshore Immigration Applicants

Onshore Immigration Applicants who apply to Department of Immigration and Border Protection (DIBP) to extend or amend their visa classification while in Australia are required to undertake health screening as part of their application. The applicant must meet the cost of this screening. However, if TB infection or disease is identified subsequent management, care and/or treatment is to be provided free of charge.

Commonwealth Immigration Detention Centre

Where TB Services are provided to a person held in a Commonwealth Immigration Detention Centre, the health service is to charge the Commonwealth Department of Immigration through its contractor at the appropriate ineligible rate.

Vaccinations outside the recommendations

- Where vaccination occurs outside of the specified NSW Health recommendations a charge must be raised.
- Other vaccinations and travel medication advice not mentioned above must be charged to the patient.
- Where the vaccination is provided by a public health service the charges should be the equivalent of an outpatient consult and the cost of the vaccine.

3.7 Mental Health

Acute mental assessments and clinically required treatment for overseas visitors and temporary residents in Australia should be provided in accordance with protocols applicable to Australian residents.

Mental health services provided to overseas visitors and temporary residents by NSW health services (whether non-inpatient or inpatient) are chargeable services.

There are two exceptions to these general charging principles:

- Unless covered by insurance, charges for periods of involuntary or compulsory mental health treatment should be waived or reduced to equal the insurance cover available. Where charges are waived, they should be reinstated once the period of involuntary or compulsory treatment has passed.
- The patient is entitled under a RHCA, the assessment and/or treatment is medically necessary, and the patient wishes to receive these health services under the RHCA.

Overseas visitors and temporary residents needing mental health assessment and treatment retain the right to make an informed choice to be a privately insured patient. The patient will not be able to claim Medicare rebates for medical and diagnostic treatments.

The insurer will be charged at the ineligible rate.

3.8 High Risk Pregnancy Services

The primary determinant of whether a health service is provided is ensuring the safety of the mother and baby.

Antenatal, maternity and postnatal services provided to overseas visitors and temporary residents by NSW public health services (whether non inpatient or inpatient) are chargeable services.

There are two exceptions to these general charging principles:

- Unless covered by insurance, charges for services when the pregnancy is high risk to mother and / or baby **and** charging for the service would result in the mother not presenting should be waived or reduced to equal the insurance cover available. Where charges are waived, they are to be reinstated once the need for high risk treatment has passed.
- The mother is entitled under a RHCA, the assessment and / or treatment is medically necessary, and the mother wishes to receive these health services under the RHCA.

Where appropriate, mothers are to be encouraged to access routine antenatal and postnatal services which are widely available from private sector GPs, midwives and obstetricians.

3.9 Refugees and Asylum Seekers

3.9.1 Refugees

Persons with refugee status who are settled in Australia under the Humanitarian Migration Program are permanent residents with full Medicare eligibility. However, if very newly arrived there may be delays in allocating a Medicare number. Patients with refugee status must be treated as fully eligible and the health service are to seek to identify the number as it is issued.

3.9.2 Asylum seekers living in the community

Asylum seekers fall into one of four categories while awaiting refugee status:

1. Asylum seekers provided with a blue (interim) or green (full) Medicare card which allows them access to health care with the same rights as an Australian permanent resident
2. Asylum seekers eligible for federally funded health and welfare schemes such as the Asylum Seekers Assistance Scheme (ASAS)
3. Asylum seekers ineligible for Medicare or the ASAS
4. Asylum seekers in community detention with healthcare funded by a contracted provider (see section 3.10)

Urgent clinical treatment for anyone presenting to a NSW health service should not be delayed while their status and eligibility are being determined.

3.9.3 Determining status for asylum seekers

Asylum seekers without a Medicare card will hold one or more of the following documents:

- A Bridging Visa, which is most commonly of type ‘E’ (with the letters WE stamped on visa), but also may be type ‘A’ or ‘C’. More information about visa types is readily available online.
- A document from the Department of Immigration and Border Protection (DIBP), which may take the form of:

- An acknowledgement letter that refers to the person's immigration status (Bridging Visa Type) or
- A receipt that includes details of the person's Bridging Visa type.

- Supporting documentation from a status resolution support service which administers the ASAS on behalf of the Department of Immigration such as:
  - Australian Red Cross
  - Life Without Barriers.
- DIBP documentation indicating that the person is in Community Detention and that health care is the responsibility of the contracted provider or
- Documentation from a service providing health care to asylum seekers, such as:
  - Asylum Seekers Centre
  - NSW Refugee Health Service.

3.9.4 Asylum Seeker Assistance Scheme (ASAS) eligible asylum seekers

Where a person covered by ASAS, is hospitalised in a NSW public hospital, they are to be classified and charged using the asylum seeker financial classifications.

They will have a letter from a support organisation which will:

- Be addressed to a specific health service and
- Identify the patient and
- Identify the patient's condition to be treated.

Services outside the scope of the letter must not be provided without the written authority of the support organisation.

In addition to accommodation charges raised at the ASAS rate, the following billing accounts are to be rendered by the health service to the support organisation:

- Diagnostic accounts or accounts for services provided by staff specialists exercising their right of practice
- Surgically implanted prostheses
- Non-inpatient occasions of service
- Non-inpatient pharmaceuticals.

Emergency circumstances may arise which require hospitalisation of an individual who indicates eligibility to ASAS but is not in receipt of the required documentation. Treatment should not be delayed in these cases.

At the earliest opportunity following treatment, the identified support group must be contacted to determine eligibility.

The outcome will determine the course of action to be taken by the health service:

- Bill the support group where accepted under ASAS or
- Follow the process below for non-eligible asylum seekers.

3.9.5 Process for non-eligible asylum seekers

Not all asylum seekers are financially disadvantaged; some seek refuge from political or religious persecution and have the means to support themselves.

Where a person identified as an Asylum Seeker but not eligible for ASAS or a Medicare card, it is a requirement that health services:

- Determine eligibility for treatment at no charge in accordance with the other procedures in this document i.e. victim of crime
- Charge outpatient and inpatient fees at the ineligible rate (see Section 4) or
- Evaluate any request for reduction or waiver for persons who do not have the means to pay by ensuring a financial hardship or other appropriate review has been undertaken and approval obtained from the Director of Finance or equivalent delegation.

3.10 Immigration Detention Centre patients

The Commonwealth Department of Immigration and Border Protection are responsible for the provision of health services for persons in immigration detention, including Community Detention. The Department arranges health services through contracted providers. The contracted providers have a network of private sector health care professionals and they also utilise public sector health services.

Services for immigration detainees will be pre-arranged by the detention centre or contracted provider.

NSW health services must bill the contracted provider for all health services provided to a person in immigration detention, including community detention.

Details of the current provider are available in the Immigration Detention Quick Guide on NSW Health Revenue Toolkit quick guide page.

3.11 Norfolk Island citizens

From 1 July 2016, residents of Norfolk Island are covered by Australian Government Medicare arrangements. Health services must ensure accurate capture of Norfolk Island residential address including postcode.

Norfolk Island residents are eligible for Australian Medicare cards and unless compensable, may elect to be treated as public or private patients for treatment by NSW Health services. Hospitals will enter private, public or relevant compensable financial classification into the local patient administration system (PAS).

Norfolk Island financial classifications are no longer required and will cease being used from 1 July 2016.

3.12 CAFAT, ROMAC or other specific agreement

A number of agreements exist where Medicare ineligible patients are referred for health services in Australia. Some arrangements are government funded and others are funded by charities and other non-government agencies. The arrangements provide assistance

to residents of countries in the South Pacific, Oceania and other regions who might benefit from access to specialist health services in Australia.

NSW health services may accept referrals of patients for treatment under these arrangements provided that prior written approval and guarantee of payment are received.

3.12.1 CAFAT

The government of New Caledonia operates the CAFAT social security and health benefit scheme. Persons covered by the scheme will have a written authority outlining what services are covered and the billing arrangements.

3.12.2 ROMAC

ROMAC (Rotary Oceania Medical Aid for Children) is a charitable program established and supported by Rotary to assist children requiring specialist services (usually surgical) that cannot be provided in their home country or another nearby country. Persons being assisted by this scheme will have a written authority outlining what services are covered and the billing arrangements.

3.12.3 Other

In some circumstances, clinical staff may donate their time and/or the health service might arrive at an agreement with organisations or individuals regarding particular donations of time or services. In such circumstances, the suggested rate would be based on the concessional (Asylum Seeker) rate, specified in the NSW Health Policy Directive *Health Services Act 1997 - Scale of Fees for Hospital and other Health Services* (PD2020_025).

3.13 Visas - student, work and other temporary residents

Certain temporary visa holders are required as a condition of their visa to have health insurance. These include students, persons permitted to enter Australia for work and retirees.

If the patient is from a country with a reciprocal health care agreement (RHCA) with Australia, refer to the advice specific to their country of origin in section 3.5 of this document.

If a visa holder with a requirement to hold private health insurance, overseas student health cover (OSHC) or overseas visitor health cover (OVHC) cannot produce evidence of appropriate health insurance, they must be charged as an ineligible patient.

Private health insurance policies for temporary visa holders in Australia are different to policies for Australian residents who are eligible for full Medicare. Eligibility checks for patients presenting with these types of policy are critical to ensuring the patient is fully informed about the costs they may incur.

NOTE: More information on specific visas and verification of visas can be found in the Visa Quick Guide on the Revenue Toolkit quick guide page.

3.14 Overseas visitors other than those covered in previous sections

Patients must be classified Medicare Ineligible and fees charged:

- To the individual where there is no insurer, or no confirmation of payment from an insurer
- To the Australian or international insurer when eligibility and confirmation of payment has been established
- To the responsible party in special circumstances i.e. members of the defence forces from countries on official exchange with the Australian Defence Force

NOTE: Diplomats and their families from countries not specified in a RHCA as well as New Zealand and Norway are considered Medicare Ineligible and must be charged at the ineligible rate for all health services.

4 PATIENT ADMINISTRATION AND REVENUE MANAGEMENT

4.1 Patient classification and registration

Whilst clinical assessment and treatment of an urgent condition must not be delayed, health services must ensure that administrative, nursing or medical staff obtain the following details when any person presents for treatment:

- Full name and date of birth
- DVA card colour and number (if applicable)
- Defence Force PMKeys number (if applicable)
- Private health insurance details, name of fund, policy / account number and contact details (including international or overseas funds)
- Permanent residential address (overseas, if applicable)
- Temporary residential address (Australian)
- Mobile and any other contact phone numbers
- Email address
- Country of birth
- Marital status
- Aboriginal or Torres Strait Islander status
- Next of kin name and contact details
- Name of local GP (if applicable)
- If patient is being treated as a result of a compensable accident or incident.

4.1.1 Further evidence required if patient does not hold a Medicare card:

Compensable	Debtor details
Prisoner	None but must present with prison staff

Victim of crime	None but must present with police or an official police notification
Organ donor	None
Infectious control and public health containment	Copy identifying documentation with photo i.e. passport and/or licence (Australian or overseas) Copy visa type, class and date of entry to Australia from passport or immigration documentation Copy any document from other health services Any extra details as required by infection control team
Resident of Norfolk Island:	Ensure accurate capture of Norfolk Island residential address, including postcode Charge PHI or individual where patient has elected to be treated as a private patient Follow existing recovery processes where patient is treated as a compensable patient Where patient has elected to be public, LHD will raise the MoH as a debtor and the MoH will make a six monthly reconciliation and payment to the LHD based on PAS information
Overseas visitor, immigration detainee or Asylum seeker:	Copy identifying documentation with photo i.e. passport and / or licence (Australian or overseas) Copy or verify visa type, class and date of entry to Australia from passport, immigration documentation or immigration website; instructions for verification of visas can be found in the Visa Quick Guide on the Revenue Toolkit quick guide page Copy any documents with prior approval for treatment and billing Credit card details or details of other payment methods / agreements (including waivers or reduction of charges by CE or similar delegation level) if treatment is not paid for in advance.

4.1.2 Extra details required for RHCA patients:

If patient is from Belgium, the Netherlands or Slovenia and accessing medically necessary treatment through the RHCA: copy valid European Union Health Insurance card.

If patient is from Sweden and holding a student visa (500, 570 – 576, 580, or

590) and accessing medically necessary treatment through the RHCA: copy valid Swedish National Board of Student Aid (CSN International) card.

4.2 Charging and collection procedure

Medicare Ineligible patients who are not eligible for free or compensable treatment under section 3 of this document must be charged according to section 5: Fees and Charges

4.2.1 Insured admitted patients:

- Complete ineligible patient declaration
- Copy passport including visa type and class
- Copy health insurance card / notice
- Contact the health insurer and confirm patient eligibility for treatment and excess rate (if not eligible follow process for non-insured and non-guaranteed patients)

- If overseas fund, request written confirmation that accounts will be paid (if not eligible follow process for non-insured and non-guaranteed patients)
- Charge any excess to the patient prior to treatment
- Send all accounts to insurer (Australian or payment confirmed) or patient in a timely manner.

4.2.2 Patients with prior written approval for treatment and billing (e.g. ROMAC, ASAS):

- Complete ineligible patient declaration
- Copy identification
- Copy any documentation including written letters of introduction or approval
- Send all accounts to approving organisation in a timely manner.

4.2.3 For non-insured, non-guaranteed admitted patients and non-admitted patients:

- Complete ineligible patient declaration
- Copy passport including visa type and class
- If Visa class must be insured but is not, follow procedure to notify to Department of Immigration and Border Protection (DIBP) Section 6
- Ensure patient is fully informed of the costs likely to be incurred, the estimate of cost forms may be used to assist with this
- Raise accounts at the time of booking/admission or prior to discharge with as much detail as possible to allow patients to claim from travel or overseas insurers with no guarantee.

Receive payment in the following priority order:

1. In advance of booked procedures or services with a written understanding that further accounts may be raised following the procedure
2. Prior to or at the time of service in cash or by EFTPOS
3. Prior to discharge of inpatients in cash or by EFTPOS
4. In instalments by direct debit agreement
5. In instalments with a written agreement with patient or family.

Facilitation

Health services must ensure that staff is able to receive payment and/or confirm credit card pre-authorisation.

4.3 Booked patients

Ensure the ability of NSW Health to fund the treatment of overseas patients does not interfere with the physical, clinical and / or financial capacity of any health service to meet clinical priorities for Australian residents.

4.4 Guarantor agreements

If it is likely that a Medicare Ineligible patient, or prospective patient, may be unable to pay for some or all of the costs of the medical and other services that are expected to be provided to that patient, it will be necessary for the relevant financial officer to consider whether it would be appropriate to request a supporting patient guarantee from a suitable person. A suitable person would be a person who is willing to provide a guarantee to support the future financial obligations of the patient to the Hospital in respect of the required medical services. A suitable guarantor may be a family member of the patient, or another third-party associate of the patient.

Before deciding to seek or accept a guarantee from a prospective guarantor, it will be appropriate to consider whether that person is a suitable person to provide such a guarantee. Matters such as their country of residence or financial capacity *are* relevant.

The factors to be considered, and processes to be followed, when seeking a guarantee of the patients liabilities from a suitable supporting person are outlined *in Attachment B*: Medicare Ineligible Financial Guarantees - Guide for Revenue or Finance officers.

The processes and procedures set out in this Information Guide are to be followed whenever a supporting patient guarantee is sought from a third person.

When taking a supporting guarantee, it is recommended that the standard template Guarantee document be used, together with the template Information Statement for Guarantors.

4.5 Payment by instalment

Where it is necessary to set up a payment plan, health services must follow a delegation and approval process to set up and manage instalment plans in a fair and reasonable manner with realistic timeframes.

4.6 Debt recovery

Normal debt recovery action are to be undertaken, and a debt not written off until every avenue has been exhausted and it is clear that payment is not achievable.

4.7 Waiving or reducing charges

If a patient or person responsible for paying fees claims financial hardship the LHD must conduct a financial hardship or other review in accordance with local policy.

Except in the circumstances indicated in section 3 of this document, fees should not be waived or reduced unless a financial hardship or other appropriate review *in accordance with local policy* has been undertaken and approval obtained from the Chief Executive or similar delegation.

Where fees are waived it is with the understanding that the costs of treatment are the responsibility of the LHD.

5 FEES AND CHARGES

Ineligible patients who have not been determined eligible for treatment at no charge under section 3 of this document must be charged for all services as scheduled, or if not scheduled on a full cost recovery basis.

Scheduled fees charged by the health service are set out in the appropriate schedules and advised by the NSW Ministry of Health at least annually, these include:

NSW Health Policy Document	
(PD2020_025)	Health Services Act 1997 – Scale of Fees for Hospital and other Health Services
(PD2021_009)	Charging Arrangements for Pension Based Scale of Fees
(PD2006_050)	Health Records and Medical / Clinical Reports – charging policy
(IB2020_048)	Pharmaceutical Charges for Hospital Outpatients and Safety Net Thresholds
(IB2019_011)	Fee for Cremation Certificates Issued by Salaried Medical Practitioners of Public Hospitals
(PD2020_029)	Ambulance Service- Charges
National Schedule	
Prostheses Rebate List	

In lieu of further information, full cost recovery may be determined by cost of item

+17% on costs.

Policy documents and guidelines can be found on the NSW Health Policy Distribution System website.

5.1 Fees for hospital, medical and diagnostic services

5.1.1 Admitted patients

Accommodation and related services - for all gazetted rates refer to the NSW Health Policy Directive *Health Services Act 1997 – Scale of Fees for Hospital and Other Services* (PD2020_025).

- Asylum seekers are charged a scheduled rate
    - Charges are raised applying the same rules as a Medicare eligible private patient (i.e. pharmacy included)
- Specific classes of Insured Visa holders are charged at the gazetted rate as per the Schedule of Fees & Charges Summary
- All other chargeable Medicare ineligible patients are billed a gazetted rate covering accommodation in a shared room, meals, nursing care and inpatient dressings as required
    - Rates are adjusted for critical care, sub-acute care, maintenance dialysis and hospital in the home

    - Inpatient pharmacy items must be charged at a full cost recovery rate
- Surgically implanted prostheses must be charged at a full cost recovery rate
- *Medical and diagnostic services*
- Work and Student visa holders covered by private insurance, OSHC or OVHC should be charged up to the equivalent applicable Medicare Benefits Schedule (MBS) fee
    - All other ineligible patients should be charged up to the current AMA rates for medical consults and diagnostics
    - If the patient is admitted but not seen by a specialist with rights of private practice, or the VMO is not prepared to accept the Medicare Ineligible patient as a private patient, then the patient should be charged the daily ineligible treatment fee in lieu of specialist billing being raised

5.1.2 Non-admitted patients (outpatient)

The following applies to all Medicare Ineligible non-admitted patients who are not eligible for treatment at no charge under section 3 of this document.

Where no specific schedule exists, the AMA scheduled rate or the scheduled (gazetted) flat rate per Occasion of Service (OOS) may be used for charging purposes. Charges must be raised and paid prior to each service.

- Emergency department services and diagnostics per OOS
- Outpatient services for nursing and day care must be charged at the scheduled flat fee per OOS
- Allied health services must be charged at the scheduled rate
- Patients must be regarded as private patients for medical and diagnostic services provided by doctors with rights of private practice.
- Patients treated by doctors without rights of private practice (i.e. ED) must be charged at the scheduled flat fee per OOS
- Outpatient pharmacy items must be charged according to the schedule
- Dressings, aids and equipment for mobility, communication, respiratory function or self-care are to only be supplied if no other supplier is available and must be charged at a full cost recovery rate
- Requests for medical records or cremation certification must be charged according to the schedules.

5.1.3 Determining Occasion of Service (OOS)

Where the flat fee is being charged there may be more than one OOS per episode.

- Pathology will always have a minimum of 2 OOS (collection and testing). If more than one area of pathology testing is required then one collection OOS for each type of collection, e.g.:
    - Blood collection or other forms of venesection

- Swabs
- Faeces, semen or sputum collection.

And one collection OOS for each area of testing:

- Histopathology / Cytopathology
- Chemical pathology
- Genetics
- Haematology
- Immunopathology
- Microbiology.

- Imaging: each type of imaging is counted as a separate OOS
  - X-ray
  - CT scan
  - Nuclear medical scans
  - MRI scans
  - Ultrasound.
- Consult: normally only one consult OOS will be applied to each episode however if a multidisciplinary approach is required each speciality may raise a charge.

5.1.4 Services provided as part of an Emergency Department non-admitted patient episode

- Where patient is only seen in the emergency department the scheduled flat fee will apply to each OOS
- The consult flat fee should be charged prior to the patient being treated but urgent clinical assessment and treatment should not be delayed for this
- All other OOS must be charged either by the service providing (according to the section above) or by ED prior to the patient leaving the facility

5.2 Charges for patient transport

Primary Transport (from site of accident or emergency to hospital)

All persons are responsible for the cost of their primary Ambulance transport.

Inter-hospital transport (transport for continuation of treatment)

Medicare Ineligible patients eligible for treatment at no charge under section 3 of this document will not have patient transport charges raised against them for inter-hospital transport.

Medicare Ineligible Visa holders with private, OSHC or OVHC will have patient transport charges raised by the health service, to their insurer, for inter-hospital transport costs.

Asylum seekers who have had agreed costs accepted will have transport charges raised by the health service, to their insurer or organisation, for inter- hospital transport costs.

All other Medicare Ineligible patients will have charges raised by the health service for inter-hospital transport.

Transport for repatriation (transport to patient's residence or place of the patient's choosing)

Patient transport must not be used for these purposes, arrangements such as taxi or private transportation should be used and payment for these services will be the patient's responsibility. If, in exceptional circumstances, patient transport is used, then charges must be paid upfront by the patient.

NOTE: All charges will be raised in accordance with the rates set in the NSW Health Policy directive Ambulance Service – Charges.

5.3 Remuneration to specialists

5.3.1 Inpatients

If the patient is only admitted to the ED or the VMO is not prepared to accept the Medicare Ineligible patient as a private patient, the health service will pay VMOs who provide service to these patients on the same basis as payment for eligible public admitted patients and charge the daily medical treatment fee.

5.3.2 Outpatients

For Medicare Ineligible persons who are eligible for treatment at no charge under Section 3 of this document, the health service will pay VMOs who provide medical and diagnostic services to on the same basis as payment for a public patient.

The health service will pay VMOs who provide medical services to Medicare Ineligible ED only non-admitted patients on the same basis as payment for Medicare eligible ED only non-admitted patients.

Services provided by salaried specialists to these patients are part of their employment by the health service and no additional payment is required.

6 WORKING WITH SERVICES AUSTRALIA AND DEPT OF HOME AFFAIRS

6.1 Reporting Medicare fraud

Most people are honest and use Medicare fairly, but if you have information about someone who is misusing Medicare it is important to contact the Department of Human Services.

Medicare fraud includes:

- Making Medicare claims for services that were not provided
- Using someone else's Medicare card
- Using an invalid concession card

- Forging prescriptions for PBS medicines.

To report suspected Medicare fraud, call **131 524** or fill out the Reporting suspected Medicare fraud form

6.2 Reporting immigration fraud

The following are examples of Immigration and Citizenship offences or fraud, it is important to report suspected fraud.

Immigration fraud includes where you suspect a person:

- Maintain adequate health insurance due to visa class but person is uninsured
- Has overstayed their visa and does not hold a valid visa to remain in Australia
- Is working illegally (for example, a tourist visa holder who is working)
- Deliberately lied on their visa application or provided false documents to the department
- Is on a student visa but is not studying
- Is visiting Australia to promote extremist ideologies, advocate violence as a means to an end, or to vilify a segment of the community
- Owes a debt to the Australian Commonwealth government.

To report suspected immigration fraud call **1800 009 623** or fill out the Reporting Immigration fraud form.

7 ATTACHMENTS

Attachment A - Estimate of cost and agreement to pay forms (examples)

- Medicare Ineligible – Inpatient estimate of cost and agreement to pay
- Medicare Ineligible with Visas 401, 403, 416, 420, 457, 485, 500, 570 to 576, 580 or 590 Inpatient estimate of cost and agreement to pay
- Medicare Ineligible Asylum Seeker - Inpatient estimate of cost and agreement to pay
- All Medicare Ineligible - Non-admitted Patient estimate of cost and agreement to pay

Also available on Revenue Toolkit Forms page

Attachment B - Guarantee of Payment

- Medicare Ineligible Financial Guarantees - Guide for Revenue or Finance officers
- Information Statement for Guarantor – Guarantees
- Deed of Guarantee

Attachment C - RHCA ready reckoner

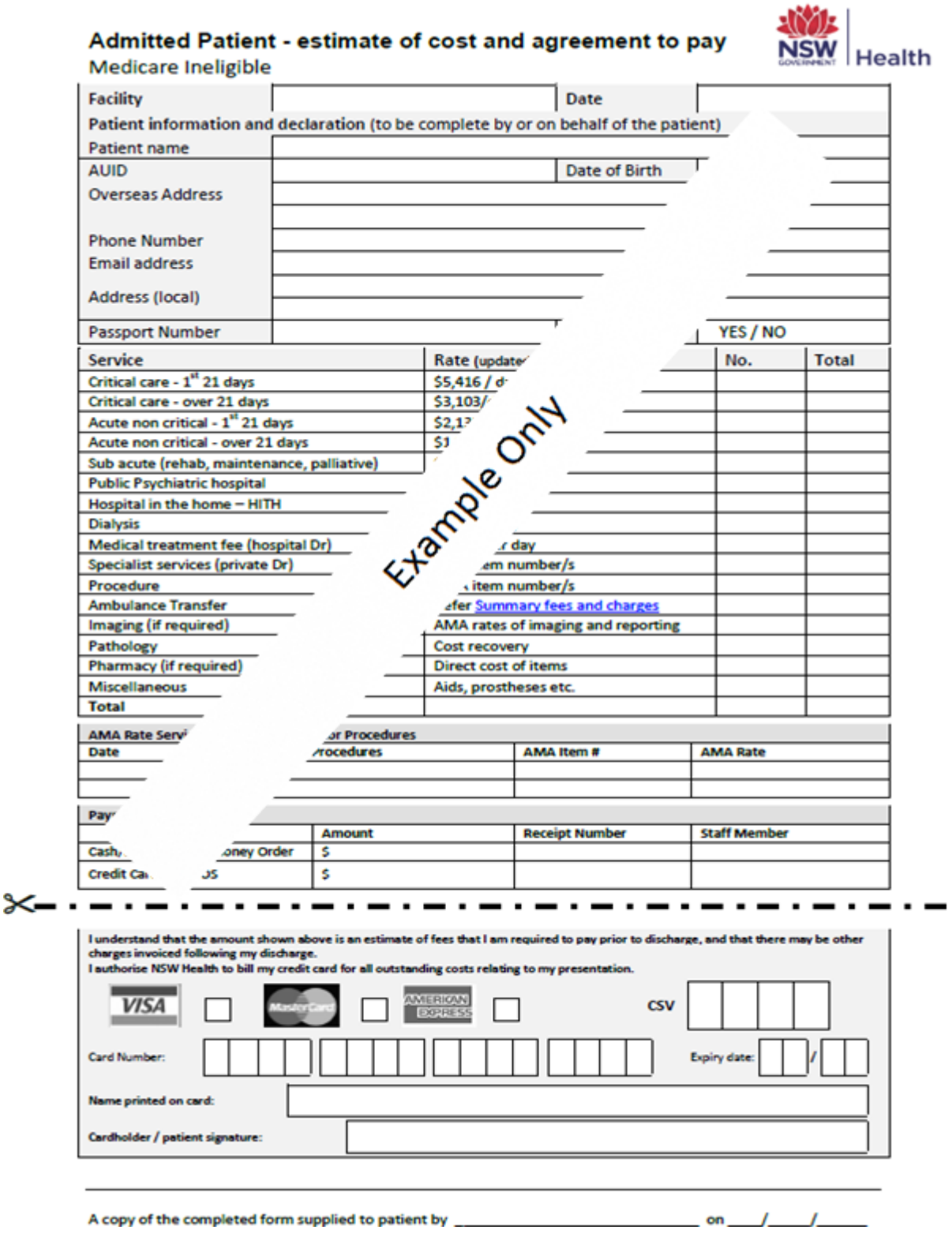
Attachment D – Withdrawal of previous Policy Directives

Attachment E – Implementation Checklist

Attachment A – Cost estimates and agreement to pay form examples

Medicare Ineligible – Inpatient estimate of cost and agreement to pay

Example only – see Revenue website forms page for up-to-date document



Admitted Patient - estimate of cost and agreement to pay

Medicare Ineligible

NSW Health

Facility		Date	
Patient information and declaration (to be complete by or on behalf of the patient)			
Patient name			
AUID		Date of Birth	
Overseas Address			
Phone Number			
Email address			
Address (local)			
Passport Number			YES / NO

Service	Rate (update	No.	Total
Critical care - 1st 21 days	$5,416 / d		
Critical care - over 21 days	$3,103/		
Acute non critical - 1st 21 days	$2,1?		
Acute non critical - over 21 days	$1		
Sub acute (rehab, maintenance, palliative)			
Public Psychiatric hospital			
Hospital in the home – HITH			
Dialysis			
Medical treatment fee (hospital Dr)	r day		
Specialist services (private Dr)	em number/s		
Procedure	item number/s		
Ambulance Transfer	efer Summary fees and charges		
Imaging (if required)	AMA rates of imaging and reporting		
Pathology	Cost recovery		
Pharmacy (if required)	Direct cost of items		
Miscellaneous	Aids, prostheses etc.		
Total			

AMA Rate Servi	or Procedures		
Date	rocedures	AMA Item #	AMA Rate

Pay			
	Amount	Receipt Number	Staff Member
Cash	oney Order $		
Credit Ca	JS $		

I understand that the amount shown above is an estimate of fees that I am required to pay prior to discharge, and that there may be other charges invoiced following my discharge.
I authorise NSW Health to bill my credit card for all outstanding costs relating to my presentation.

VISA ☐ MasterCard ☐ AMERICAN EXPRESS ☐ CSV

Card Number: Expiry date: /

Name printed on card:

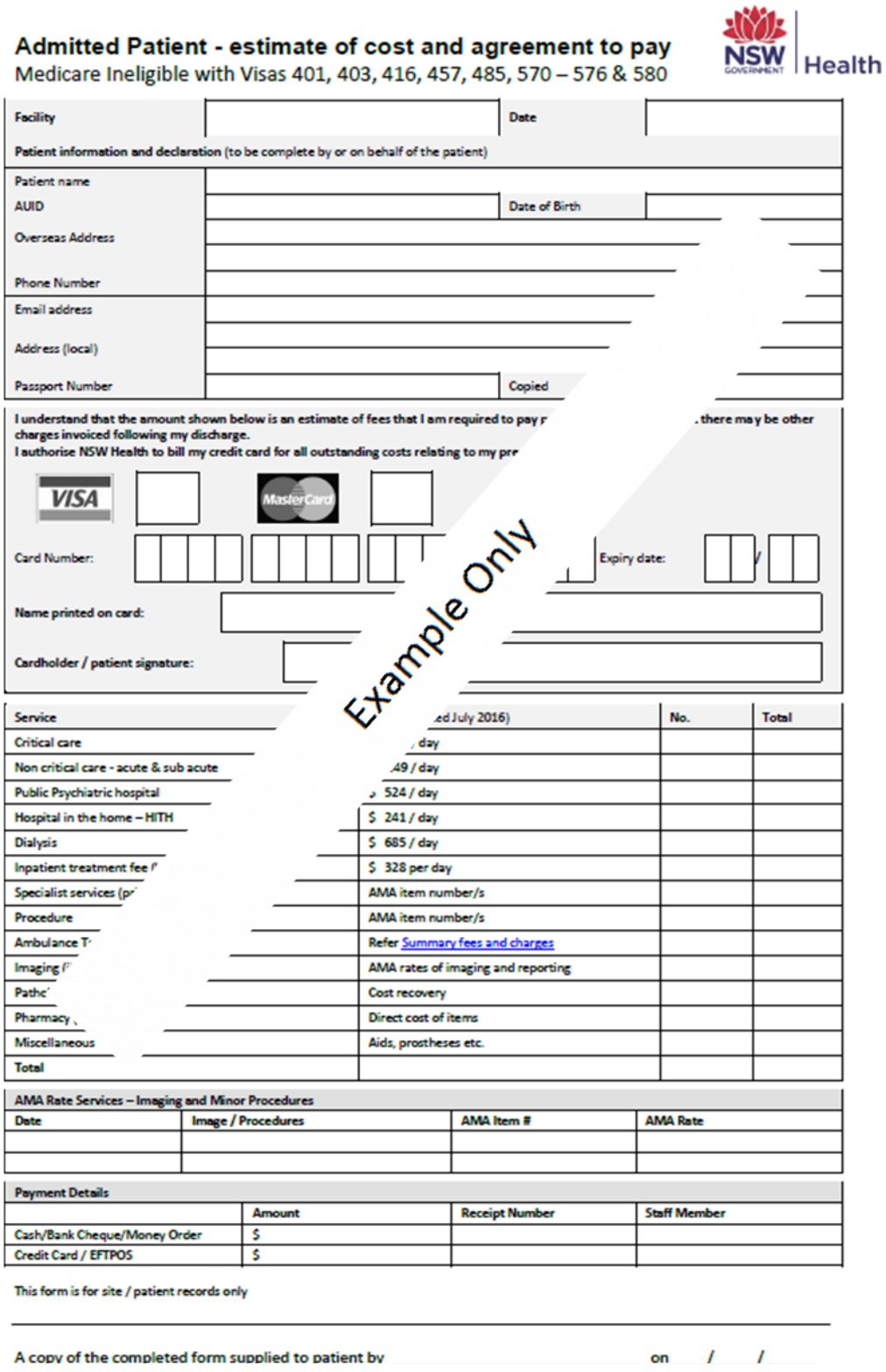
Cardholder / patient signature:

A copy of the completed form supplied to patient by _____ on ___/___/_____

Example Only

Medicare Ineligible with Visas 401, 403, 416, 420, 457, 485, 500, 570 to 576, 580 and 590 - Inpatient estimate of cost and agreement to pay

Example only – see Revenue website forms page for up-to-date document



Admitted Patient - estimate of cost and agreement to pay

Medicare Ineligible with Visas 401, 403, 416, 457, 485, 570 – 576 & 580

NSW Health

Facility		Date	
Patient information and declaration (to be complete by or on behalf of the patient)			
Patient name			
AUID		Date of Birth	
Overseas Address			
Phone Number			
Email address			
Address (local)			
Passport Number		Copied	

I understand that the amount shown below is an estimate of fees that I am required to pay f . there may be other charges invoiced following my discharge.
I authorise NSW Health to bill my credit card for all outstanding costs relating to my pre

VISA MasterCard

Card Number: Expiry date: /

Name printed on card:

Cardholder / patient signature:

Example Only

Service	ed July 2016)	No.	Total
Critical care	day		
Non critical care - acute & sub acute	49 / day		
Public Psychiatric hospital	524 / day		
Hospital in the home – HITH	$ 241 / day		
Dialysis	$ 685 / day		
Inpatient treatment fee f	$ 328 per day		
Specialist services (pr	AMA item number/s		
Procedure	AMA item number/s		
Ambulance Tr	Refer Summary fees and charges		
Imaging (r	AMA rates of imaging and reporting		
Pathc	Cost recovery		
Pharmacy	Direct cost of items		
Miscellaneous	Aids, prostheses etc.		
Total			

AMA Rate Services – Imaging and Minor Procedures			
Date	Image / Procedures	AMA Item #	AMA Rate

Payment Details			
	Amount	Receipt Number	Staff Member
Cash/Bank Cheque/Money Order	$		
Credit Card / EFTPOS	$		

This form is for site / patient records only

A copy of the completed form supplied to patient by on / /

Medicare Ineligible Asylum Seeker - Inpatient estimate of cost and agreement to pay

Example only – see Revenue website forms page for up-to-date document

Admitted Patient - estimate of cost and agreement to pay
Medicare Ineligible - Asylum seeker

NSW Health

Facility		Date	
Patient information and declaration (to be complete by or on behalf of the patient)			
Patient name			
AUID		Date of birth	
Norfolk Island address			
Phone number	Mobile	Other	
Email address			
Address mainland			
Licence or ID number		Co / NO	

I understand that the amount shown below is an estimate of aised to myself or my insurer. I understand that any amounts my insurer refuses e my responsibility.

Patient or representative signature

Service	P .6)	No.	Total
Critical care			
Single room – overnight (where available'			
Shared room – overnight	y		
Day only	day		
Dialysis	3 / day		
Inpatient treatment fee (hosp	328 / day		
Specialist services (private	AMA item number/s @100%		
Procedure	AMA item number/s @100%		
Ambulance transfer	Refer Summary fees and charges		
Imaging (if require	AMA rates of imaging and reporting		
Pathology	Cost recovery		
Pharmacy (if	Direct cost of items		
Miscellaneous	Aids, prostheses etc.		
Total			

Example Only

AMA rate services – imaging and procedures: if more than space allows, attach detail or record over page

Date	Image / Procedures	MBS Item #	MBS Rate

Payment details

	Amount	Receipt Number	Staff Member
Cash/Bank Cheque/Money Order	$		
Credit Card / EFTPOS	$		

This form is for site / patient records only

Medicare Ineligible - Non-admitted patient estimate of cost and agreement to pay

Example only – see Revenue website forms page for up-to-date document

Non-admitted Patient - estimate of cost and agreement to pay
Medicare Ineligible - all

Facility		Date	
Patient information and declaration (to be complete by or on behalf of the patient)			
Patient name			
AUID		Date of Birth	
Overseas Address			
Phone Number			
Email address			
Address (local)			
Passport Number		Copied	

As a Medicare Ineligible patient I understand I am responsible for payment ... associated with my presentation. I agree to pay in advance or prior to leaving the f...)

Cash / bank cheque / money order / Eftpos ☐ VISA ☐ MasterCard ☐

I authorise NSW Health to bill my credit card for Medicare Ine... gnostic and other services such as drug costs and equipment purchase relatin... ion.

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry date: ☐☐/☐☐

Name printed on card:

Cardholder / patient signature:

Details of Services	Rate	No.	Total
Emergency Consult	$133		
Pathology collection & first test	$266		
Pathology (other test groups)	$133		
Imaging – AMA rate	$		
Outpatient Appointment ... ital	$ 93		
Outpatient Clinic Appo... linic	$133		
Outpatient Clinic Ap... – AMA rate	$		
Minor procedure ... MA rate	$		
Purchase of eq... utches, immobilisers, etc)	$		
Other	$		
Total			

AMA Rate Servic... and Minor Procedures

Date	Image / Procedures	AMA Item #	AMA Rate

Payment Details

	Amount	Receipt Number	Staff Member
Cash/Bank Cheque/Money Order	$		
Credit Card / EFTPOS	$		

This form is for site / patient records only

A copy of the completed form supplied to patient by _____ on ____/____/____

Attachment B – Guarantee

Guide for Revenue or Finance officers
Medicare Ineligible Financial Guarantee

Overseas visitors or temporary Australian residents who are **not** Australian citizens or permanent residents are not eligible for Medicare and are required to pay for medical services.

If a Medicare ineligible patient indicates they may have difficulty or be unable to pay for some or all of the costs of the services that are expected to be provided you may request a Guarantee from a supporting person.

This guide provides information about:

- how you should engage and consult with a supporting person who may be willing to provide a Guarantee; and
- what you should and should not do or say in arranging for a supporting person to grant and sign a Guarantee in favour of the Hospital.

What is a guarantee?

A guarantee is a promise made by a person that the patient will pay, on time, the amounts owed by the patient, for services provided.

Under this promise, the guarantor will be liable for all amounts that:

- are or become payable by the patient, for services provided
- that remain unpaid by the patient
- are owing but not yet payable.

Under the promise made by the guarantor, if the patient does not pay, as agreed, the amounts raised for services, the guarantor promises to pay the amount owing as soon as the money is asked for.

The option to take a Guarantee

You may request a Guarantee from a supporting person if there is doubt about whether the patient can or will make payment of the expected costs for the services to be provided.

If you form the view that a Guarantee would provide additional protection for the health services, you may ask the patient or the person providing apparent support to the patient, such as the spouse or accompanying adult whether they or someone else would consider providing a supporting Guarantee to assist in securing amounts that will become payable.

Please see below for instructions as to what you should and should not say.

Consulting with a prospective guarantor

It is important that a prospective guarantor has the opportunity to decide whether to provide the Guarantee, without any inappropriate pressure – whether spoken or implied.

Any final discussions with a prospective guarantor should not take place in the presence of the patient. If discussions about the provision of a Guarantee initially commence in the presence of the patient, and the prospective guarantor indicates a potential willingness to provide a Guarantee, you should not conclude those discussions in the presence of the patient.

Ideally, any detailed discussions with a prospective guarantor who may be willing to provide a Guarantee should not take place in the presence of the Patient. Once you establish a potential willingness on the part of a supporting person to provide a Guarantee you should speak with the prospective guarantor alone in a room away from the patient and from any other relevant relative of the patient who may be able to influence the prospective guarantor in deciding whether or not to enter into the Guarantee.

The guarantor should be given the opportunity to reach a final decision to provide the Guarantee without the emotional presence of another person being allowed to interfere with that decision.

When speaking with a prospective guarantor, you should follow the scripts and procedures set out below.

Explain why a Guarantee is being asked for

In the initial discussion with a prospective guarantor, you should explain the reasons why the hospital is seeking the Guarantee. ***You should say:***

- *The cost of treating Medicare ineligible patients who do not pay for their treatment themselves or through third parties is met by the State of NSW. As you would appreciate, we are required to manage those costs. That is why we seek an assurance of payment, such as payment plans.*
- *The treatment the patient will receive will be determined by the treating doctor. The treating doctor will prioritise clinical need and consider the best interests of the patient. They may liaise with hospital administration and will also consider factors such as cost, available resources, competing demands for resources, and the patient's length of stay in Australia including whether it is possible for the patient to return to their home country for treatment.*
- *If you can provide an assurance of payment that may affect the decision as to what treatment pathway to take. If you have any questions about the circumstances of the patient, please raise these with the doctor.*

*You should **not** say:*

- *that the patient will not receive required services if a Guarantee is not provided;*
- *that the services provided to the patient will be conditional on a Guarantee being provided.*

*You should also explain that the supporting person is under absolutely no obligation to provide a Guarantee. **You should say:***

> *"I want to make it clear that it is entirely up to you, as to whether you decide to provide us with a Guarantee. This is strictly your decision and we will respect your decision regardless of what you choose to do. We recommend that you take the time to get advice before signing a guarantee.*

Ask the supporting person to read the Guarantee document and the guarantor Information Statement

If a prospective guarantor expresses an interest in entering into a Guarantee, you should:

- ensure the supporting person reads a copy of the Guarantee document and the guarantor Information Statement 'Information Statement – Guarantees''; *and*
- *recommend that the supporting person take the Guarantee document away with them to obtain advice;*

If a further explanation of the document is required

Ask the supporting person if they have understood the terms of the Guarantee.

If you need to explain the general nature of a guarantee, the following is an explanation of the Guarantee that you can give.

> *"If you give a guarantee in the terms of this document you will be making a legally binding and enforceable promise to the Hospital that you will be liable to make payment to the Hospital, on demand, for all outstanding amounts that are to become payable by the patient in connection with the Services that the provided to the patient by the Hospital.*
>
> *This means that if the patient does not pay the outstanding amounts for the Services he or she has received, we may seek payment from you instead. If you do not pay, we can then take enforcement action against you to recover the money originally owing by the patient. We can also recover any reasonable enforcement expenses.*
>
> *Before you agree to sign the Guarantee, you should carefully read it."*

As far as practical, you should **not** seek to explain the individual clauses of the Guarantee document or their effect. You should explain that you are not able to give advice on the particular terms of the Guarantee. You should explain that this is why the guarantor Information Statement has been provided to assist the guarantor.

If the prospective guarantor persists in seeking an explanation, you should suggest that they may wish to take separate advice if they feel the need to do so.

Explaining the 'cooling off period'

As an alternative to seeking independent advice before signing the Guarantee, the guarantor can elect to rely on the right to cancel the Guarantee during the 'cooling off' period.

You can explain this as follows.

> *"We recognise that a decision to provide support for the patient by providing a Guarantee can be a complex or difficult one.*
>
> *For that reason, if you choose to sign the Guarantee, you will have the right to cancel the Guarantee by giving the Hospital a written notice of cancellation within the two Business Days that follow after you sign the Guarantee.*
>
> *This will allow you to reconsider your choice to provide the Guarantee, or to seek additional advice about the Guarantee after you have signed it.*
>
> *Your cancellation rights and the applicable time limits of two Business Days are set out in the Guarantee document."*

Execution of the Guarantee

Once a person has agreed to sign the Guarantee, you should state:

> *You understand that you are not obliged in any way to provide the Guarantee and may decline to do so.*
>
> *You confirm that you have read and understood this document.*

The Guarantee should then be signed by the guarantor and dated. You should sign as the witness of the guarantor's signature and complete the details of your full name and address.

Translators

If the prospective guarantor requires a translator, the staff member should seek an appropriate person to communicate with the supporting person using a translation of the suggested dialogue above.

The prospective guarantor should be provided with:

a) a copy of the Guarantee; and
b) a copy of the *Information Statement – Guarantees*, including a copy of the *Deed of Guarantee*.

You should then:

- ask the prospective guarantor to return as soon as possible with a qualified translator; or
- arrange for the prospective guarantor to attend the Hospital at a time that you are able to provide a suitably qualified translator,

in each case, at an agreed time in the near future.

The same processes should then be followed with the assistance of the translator, and with the translator providing required translations to the prospective guarantor of what is being said and what is written in the documents.

The translator should then be asked to certify in writing that they have faithfully translated what you have said, as well as the contents of the Guarantee and the Information Statement. You should ask the prospective guarantor to confirm, with the assistance of the translator as required, that they have understood the terms of the Guarantee document and its effect. You should confirm that they are providing the Guarantee of their own free will.

Place and mode of execution

The following is a checklist to be completed before and after the guarantor signs the Guarantee:

Question	✓/X	Additional comments
Has the guarantor been advised to take away the guarantee document to obtain advice before signing?		
Is the Guarantee being signed in a room separate to where the Patient and any relations of the Patient are located?		*[If the answer to this question is "X", signing must be postponed until you and the Guarantor are in a room separate to the Patient and his or her relatives.]*
Who are the attendees in the room at the time of the signing of the Guarantee and what relation do they have to the Guarantor?		*[Provide a list]*
Has the Guarantor obtained any legal and/or financial advice before signing?		
In your opinion, does the Guarantor understand the capacity in which he or she is signing the Guarantee?		
In your opinion, has the Guarantor been subject to any duress, undue influence or commercial pressure to sign the Guarantee?		
Has the Guarantor received a copy of the signed Guarantee?		*[Following the execution of the Guarantee, you should provide a copy of the executed document to the Guarantor.]*
Additional notes		
Has a translator been used?		*Name* *Address* *Phone*
Does the translator certify that they have faithfully translated what has been said and the contents of any documents?		*I certify I have faithfully translated any conversations and documents.* *Translator Signature*
Does the translator confirm that the guarantor has indicated that they understand the terms of the Guarantee Document and is making the guarantee of their own free will?		*I confirm that the prospective guarantor indicates that they understand the terms of the guarantee document and are making the guarantee of their own free will.* *Translator Signature*

Information Statement for Guarantor - Guarantees

1. THINGS YOU SHOULD KNOW ABOUT GUARANTEES

You are being asked to provide (or have offered to provide) a guarantee in respect of the liabilities of the patient (**Patient**) described in the guarantee document that is being provided to you with this information statement.

This information statement tells you about some of the rights and obligations you will have as a guarantor if you sign the guarantee document (**Guarantee**). This information does not provide a full or complete description of the terms and conditions of the Guarantee. Instead, this document is designed to tell you more about what it will mean to be a guarantor of the liabilities of the Patient.

If you believe you may have difficulty paying or it will cause you financial hardship, then you should discuss your position with the Provider and consider obtaining financial counselling before doing so – see item 8 below.

2. WHAT IS A GUARANTEE?

If you sign the Guarantee you will provide a promise to the person described in the Guarantee as the "Provider". You will promise that the Patient will pay, on time, the moneys owed by the Patient to the Provider for the 'Services' that are provided to the Patient while he or she is an admitted patient of the Provider.

- The 'Services' that may be provided by the Provider, and that the Patient will be directly liable to pay for, are **all services, goods and materials that are provided to the Patient while the Patient [is/continues to be] an admitted patient of the Provider (including for accommodation, medical tests, diagnostic services, surgery, other medical or hospital services, medicines, food and other goods and materials, specialist services such as physiotherapy and all other services and materials provided to the Patient in relation to the health and wellbeing of the Patient).**
- **The liabilities of the Patient that you will guarantee (being the 'Guaranteed Money') are** all amounts that are or become payable, are owing but not yet payable, or that otherwise remain unpaid by the Patient to the Provider on any account at any time in connection with Services provided to the Patient on and following the admission date of the Patient (e.g. while the Patient is an admitted patient of the Provider).

Accordingly, if the Patient does not pay the Guaranteed Money, you promise under the Guarantee to pay the Provider all of the money owing (and any reasonable enforcement expenses) as soon as the money is asked for, and where it is payable by the Patient. If you do not pay on request, then the Provider can take enforcement action against you.

3. CAN I WITHDRAW FROM MY GUARANTEE IN A COOLING OFF PERIOD?

There is a "cooling off" period.

You can withdraw from your Guarantee by giving written notice to the Provider of your decision to cancel and withdrawal from your Guarantee **PROVIDED THAT** you provide that written notice to the Provider within 2 'Business Days' of your execution of the Guarantee (and do so in the manner provided for in clause 5 of the Guarantee).

The purpose of the cooling off period is to allow you a short period of time to review or reassess your decision to provide the Guarantee.

If you decide to withdraw from your Guarantee, this may affect the treatment pathway for the Patient. If you do withdraw your Guarantee, the Patient will remain liable to

pay, on time, the moneys owed by the Patient to the Provider for the Services provided.

4. **IF THE PATIENT DEFAULTS, DO I GET ANY WARNING THAT THE PROVIDER WANTS TO TAKE ACTION AGAINST THE PATIENT?**
   In most cases both you and the Patient will get a reasonable amount of notice of a default and of the date something must be done about the matter.

   You should immediately discuss any such notice of demand with the Patient and consider getting independent legal advice and/or financial advice.

5. **IF THE PATIENT CANNOT BE FOUND AND/OR THE PROVIDER INTENDS TO TAKE LEGAL ACTION AGAINST ME DO I GET ANY WARNING?**

   You will receive a written demand before any enforcement proceedings are taken against you.

6. **CAN THE PROVIDER TAKE ACTION AGAINST ME WITHOUT FIRST TAKING ACTION AGAINST THE PATIENT?**

   Yes. The Provider can take enforcement proceedings against you without first having taken enforcement proceedings against the Patient – for example, where the Patient is no longer in Australia.

7. **HOW MUCH DO I HAVE TO PAY THE PROVIDER IF THE PATIENT DEFAULTS?**

   You have to pay, the moneys owed by the Patient to the Provider for the Services provided plus the Provider's reasonable expenses in making you honour your contract of guarantee.

8. **WHAT CAN I DO IF I AM ASKED TO PAY OUT THE GUARANTEED MONEY AND I CANNOT PAY IT ALL AT ONCE *OR I AM IN FINANCIAL HARDSHIP?***

   Talk to the Provider and see if some arrangement can be made about paying. There are other people, such as financial counsellors, who may be able to help.

   You can speak to a financial counsellor by contacting the national debt Helpline on 1800 007 007.

9. **IF I PAY OUT MONEY FOR THE PATIENT, IS THERE ANY WAY I CAN GET IT BACK?**

   You can sue the Patient, but remember, if the Patient cannot pay the Provider, he or she probably cannot pay you back for a while, if at all.

10. **DO I HAVE ANY OTHER RIGHTS AND OBLIGATIONS?**

    Yes. The law does give you other rights and obligations. You should also **READ YOUR GUARANTEE** carefully.

DEED OF GUARANTEE

Important Notice to the Guarantor

Before you sign this document, you should ensure that you have read and understand its contents. By signing this guarantee, you will be entering into a binding commitment to pay the Guaranteed Money to the Provider (each as described in this document).

After you sign this guarantee, you will have the option of cancelling your obligations as a guarantor, but only where you do so in writing and within 2 Business Days of the time that you signed this document. (Clause 5 of this document sets out the details of this 'cooling off' period and the way in which you must act if you wish to cancel your guarantee within the period of 2 business days that is allowed as the cooling off period.)

The cooling off period that is provided for in this document will allow you to take independent advice (where you wish to do so) following your execution of this document.

Details of Provider	**[Name of Provider] Alt [ABN/ACN/ARBN] [number] Opt [whose registered office is at [address]] (the Provider) (which expression includes the Provider's successor in title, substitute or assign)**
Details of Guarantor	**[Name of Guarantor] whose address is at [address]] (Alt[a/the] Guarantor)**
Details of Guarantor ***[complete only if there is a second guarantor]***	**[Name of Guarantor] whose address is at [address]] (Alt[a/the] Guarantor)**
Details of Patient	**[Name of Patient] whose address is at [address] (the Patient)**
Date of Admission	**[year]**

THIS DEED is made on [year] between the Provider and the Guarantor.

BACKGROUND

The Patient has been, or will be, admitted as a patient who will receive Services from the Provider. To better secure the payment by the Patient of the costs of the Services being provided (and to be provided) to the Patient, the Guarantor has agreed to provide the guarantee and indemnity set out in this document.

THE PARTIES AGREE AS FOLLOWS:

1. GUARANTEE

1.1 Obligations guaranteed

The Guarantor guarantees to the Provider the due and punctual payment by the Patient of the Guaranteed Money.

1.2 Consequences of Patient's defaults

If the Patient defaults in the due and punctual payment of any Guaranteed Money, the Guarantor must pay that money on demand to, or as directed by, the Provider.

1.3 Consideration and solvency

The Guarantor represents and warrants to the Provider that:

(a) the Guarantor has received valuable consideration for entering into this document;

(b) the Guarantor considers that the Guarantor will benefit by entering into this document;

(c) this document constitutes the Guarantor's legal, valid and binding obligations, enforceable against the Guarantor in accordance with its terms; and

(d) there are no reasonable grounds to suspect that, after entering into this document, the Guarantor will be unable to pay the Guarantor's debts as and when they fall due.

1.4 Nature of obligations and enforcement

The Guarantor's obligations in this document are principal obligations (and not ancillary or collateral to any other right or obligation) and may be enforced against that Guarantor without the Provider first being required to:

(a) exhaust any remedy against the Patient or any other person; or

(b) enforce any other guarantee or Security Interest the Provider may hold relating to the Guaranteed Money.

1.5 Continuity and preservation of Guarantor's obligations

This document is a continuing guarantee. The Guarantor's obligations in this document are absolute, unconditional and irrevocable. The liability of the Guarantor under this document extends to and is not affected by the grant of any time or indulgence to the Patient or by any other circumstance, act or omission which, but for this subclause, might otherwise affect the Guarantor at law or in equity, and the Guarantor irrevocably waives any right the Guarantor may have to claim that the Guarantor's liability has been so affected.

2. LIMITATIONS ON GUARANTOR'S RIGHTS

Until the Guaranteed Money has been irrevocably paid in full, the Guarantor may not have or exercise any rights as surety in competition with the Provider or claim to be entitled (by way of contribution, indemnity, subrogation, marshalling or otherwise) to the benefit of any agreement or document to which the Provider is a party.

3. INDEMNITY IN RESPECT OF GUARANTEED MONEY

3.1 Indemnity

For the consideration mentioned in clause 1.3 the Guarantor must unconditionally indemnify the Provider against, and must pay the Provider on demand the amount of, any loss that the Provider may suffer because:

(a) any obligations in respect of the Guaranteed Money are unenforceable; or

(b) the Guaranteed Money is not recoverable from the Patient or is repaid or restored after it has been recovered,

including the amount of any Guaranteed Money (or any money which, if recoverable, would have formed part of the Guaranteed Money) that is not or may not be recoverable.

3.2 Application of the indemnity

The indemnity in clause 3.1 extends to any money that is not recoverable:

(a) because of any legal limitation, disability or incapacity of or affecting the Patient or any other person;
(b) because any transaction relating to that money was void, illegal, voidable or unenforceable;
(c) whether or not the Provider knew or should have known any of the relevant matters or facts; or
(d) because of any other fact or circumstance.

4. GENERAL INDEMNITY

The Guarantor must indemnify the Provider against, and must pay the Provider on demand the amount of, all losses (including loss of profit), liabilities, costs, expenses and Taxes that the Provider incurs in connection with the preparation, negotiation, execution, stamping or administration of, and any actual or attempted preservation or enforcement of any rights under, this document.

5. GENERAL

5.1 Demand by the Provider

A demand by the Provider under this document may be signed by any of its managers or other officers, or any of its solicitors, and served on the Guarantor at the address shown on the first page of this document or served personally on the Guarantor. If posted, with the postage prepaid, the demand will be conclusively taken to have been served in the ordinary course of post but in any event not later than two business days after posting.

5.2 Statements by the Provider

A statement by an authorised representative of the Provider on any matter relating to this document (including any amount owing by the Guarantor) is, in the absence of evidence to the contrary, to be treated as correct.

6. COOLING OFF PERIOD AND TERMINATION OF GUARANTOR'S OBLIGATIONS BY NOTICE

The Guarantor may terminate the Guarantor's obligations under this document by giving written notice to the Provider within the 2 Business Days following the date of the execution of this document, notifying the Provider of the Guarantor's election to withdraw from and cancel this document.

Such a notice of withdrawal and cancellation must be given to the Provider, within the required time, by one of the following means:

(a) by hand delivery to the Provider at [*set out address and other requirements*] marked for the attention of [*set out the details*];

(b) by fax to the following fax number [*set out the applicable fax number*];

(c) by email to [set out the applicable email address

The Provider will acknowledge receipt of a written notice from the Guarantor that has been given in accordance with this clause 5.1.

6.2 Execution by less than all parties

This document binds each of the persons executing it even if:

(a) one or more of the persons named in this document as a Guarantor does not execute this document or is not bound or ceases to be bound by this document; or

(b) the Provider does not execute or only subsequently executes this document.

7. INTERPRETATION

7.1 Definitions

The following definitions apply in this document.

Admission Date is the date described as the Admission Date on page 1 of this document.

Business Day means a day (other than a Saturday, Sunday or public holiday) on which banks are open for general banking business in Sydney, Australia.

Government Agency means: a government or government department or other body; a governmental, semi-governmental or judicial person including a statutory corporation; or a person (whether autonomous or not) who is charged with the administration of a law.

Guaranteed Money means all amounts (including damages) that are payable, owing but not yet payable, or that otherwise remain unpaid by the Patient to the Provider on any account at any time in connection with Services provided to the Patient on and following the Admission Date, whether present or future, actual or contingent or incurred alone, jointly, severally or jointly and severally and without regard to the capacity in which the Patient is liable.

Patient means the person named on page 1 as the Patient and includes the Patient's successor in title, permitted substitute or a permitted assign.

Security Interest means: a security interest that is subject to the *Personal Property Securities Act 2009* (Cth); any other mortgage, pledge, lien or charge; or any other interest or arrangement of any kind that secures the payment of money or the performance of an obligation or which gives a creditor priority over unsecured creditors in relation to any property.

Services means all services, goods and materials (including any prosthesis) provided to the Patient while the Patient is an admitted patient of the Provider, including for accommodation, medical tests, diagnostic services, surgery, other medical or hospital services, medicines, food and other goods and materials, allied health services such as physiotherapy and all other services and materials provided to the Patient in relation to the health and wellbeing of the Patient.

Tax means a tax, levy, duty, charge, deduction or withholding, however it is described, that is imposed by law or by a government agency, together with any related interest, penalty, fine or other charge.

7.2 Multiple Guarantors

If a term is used in this document to refer to more than one Guarantor then, unless otherwise specified in this document:

(a) an obligation of those Guarantors is joint and several;

(b) a right of those persons is held by each of them severally; and

(c) any other reference to that party or that term is a reference to each of those persons separately.

•

- A singular word includes the plural and vice versa.

EXECUTED as a deed
SIGNED, SEALED and **DELIVERED** by **[NAME OF PARTY]** in the presence of:

_____
Signature of party

_____
Signature of witness

_____
Name

_____
Address of witness

SIGNED, SEALED and **DELIVERED** by **[NAME OF PARTY]** in the presence of

_____
Signature of party

_____
Signature of witness

_____
Name

_____
Address of witness

Attachment C – Reciprocal Healthcare Agreement Ready Reckoner

Country and Conditions	Tourist, short term visitor or visa other than those to the right >	Student Visa 500, 570-576, 580 & 590	Work Visa 401, 403, 416, 420, 457 or 485	Retirement Visa 405 or 410	Diplomat
United Kingdom: Must show a current UK passport (including those issued in the Isle of Man, Jersey or Guernsey) and have lived in the United Kingdom within the past five years. Or hold an Australian Medicare Card	ELIGIBLE as long as the conditions to the left are met.	ELIGIBLE as long as the conditions to the left are met.	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	ELIGIBLE for full Medicare coverage
New Zealand Must show a current NZ passport or be a permanent residents who holds a Returning Residents Visa **New Zealand** citizens living permanently in Australia are eligible for **full access** to Medicare (Green card)	ELIGIBLE for PUBLIC HOSPITAL ONLY, as long as the conditions to the left are met.	ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.	ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.	ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.	NOT ELIGIBLE
Republic of Ireland: Must show a current Republic of Ireland passport. Not eligible for a RHCA Medicare card	ELIGIBLE for PUBLIC HOSPITAL ONLY, as long as the conditions to the left are met.	NOT ELIGIBLE	ELIGIBLE for PUBLIC HOSPITAL ONLY as long as the conditions to the left are met.	NOT ELIGIBLE	ELIGIBLE for full Medicare coverage

Country and Conditions	Tourist, short term visitor or visa other than those to the right >	Student Visa 500, 570-576, 580 & 590	Work Visa 401, 403, 416, 420, 457 or 485	Retirement Visa 405 or 410	Diplomat
Italy: Must show a current Italian passport showing visitor is a Citizen of Italy (resident is not sufficient) EXCLUDES maintenance dialysis	ELIGIBLE but only for six months from date of entry to Australia	NOT ELIGIBLE	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	ELIGIBLE for full Medicare coverage
Malta: Must show a current passport issued In Malta showing visitor is a Citizen of Malta (resident is not sufficient) EXCLUDES maintenance dialysis	ELIGIBLE but only for six months from date of entry to Australia	NOT ELIGIBLE	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	ELIGIBLE for full Medicare coverage
Sweden: Must show a current Swedish passport and a valid Swedish National Board of Student Aid (CSN International) card	ELIGIBLE as long as the conditions to the left are met.	ELIGIBLE as long as the conditions to the left are met.	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	ELIGIBLE for full Medicare coverage
Belgium: Must show a current Belgian passport and a current European Union Health Insurance card	ELIGIBLE as long as the conditions to the left are met.	ELIGIBLE as long as the conditions to the left are met.	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	NOT ELIGIBLE

Country and Conditions	Tourist, short term visitor or visa other than those to the right >	Student Visa 500, 570-576, 580 & 590	Work Visa 401, 403, 416, 420, 457 or 485	Retirement Visa 405 or 410	Diplomat
Finland: Must show a current passport issued in Finland. EXCLUDES maintenance dialysis	ELIGIBLE as long as the conditions to the left are met.	NOT ELIGIBLE	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	ELIGIBLE for full Medicare coverage
Norway: Must show a current Norwegian passport	ELIGIBLE as long as the conditions to the left are met	Not Eligible.	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	NOT ELIGIBLE
Slovenia: Must show a current Slovenian passport and a current European Union Health Insurance card	ELIGIBLE as long as the conditions to the left are met.	ELIGIBLE as long as the conditions to the left are met.	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	NOT ELIGIBLE
Netherlands: Must show a current Dutch / Netherlands passport and a current European Union Health Insurance card	ELIGIBLE as long as the conditions to the left are met.	ELIGIBLE as long as the conditions to the left are met.	ONLY ELIGIBLE if holding a current Medicare Card	ONLY ELIGIBLE if holding a current Medicare Card	ELIGIBLE for full Medicare (not subject to medically necessary rules)

Attachment D – Withdrawal of previous Policy Directives

PD2005_045 *Medicare Ineligible Charging Arrangements for Non Inpatients*
PD2005_411 *Detention Centre – Commonwealth Use of NSW Health Services*
PD2005_508 *Overseas Visitors – Treatment of in NSW Public Hospitals*
PD2005_528 *Asylum Seekers Assistance Scheme - Provision of Hospital Services* PD2009_068 *Asylum Seekers - Medicare Ineligible - Provision of Specified Public Health Services*

8 GLOSSARY OF TERMS

Valid Medicare Card

Name is consistent with other identification and dates of service provided are within dates on card.

Eligible Insurance

Insurer has been contacted, insurance cover is appropriate to treatment and payment has been guaranteed.

Health Service

Inclusive of NSW public: hospitals, outpatient clinics, community health, mental health, palliative care, transactional teams, executive teams, and any other location or service directly related to NSW Health

9 APPENDIX LIST

Add appendices and build the appendix list below, if required.

1. Implementation / Compliance Checklist

9.1 Implementation checklist and compliance self-assessment

Organisation / Facility:	

Assessed by:	**Date of Assessment:**		
Key Policy Requirements	**Not commenced**	**Partial compliance**	**Full compliance**
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		