NSW Ambulance

excellence in care

Application for Fee Review
Non-Financial Hardship

Invoice Details	
Invoice Number:	
Amount Due:	
Due Date:	

Important Information

Prior to the lodgment of this form – *please note that the exemption may be available if you held a valid Customer Reference Number (CRN) issued from the Centrelink or held a private health fund membership at the time of the service. Please provide following information, if applicable.*

CRN and/or Private Health Fund Membership	☐ *YES*	☐ *NO, I do not have one Please proceed to Section A*	
CRN		Name of Private Health Fund & Membership Number	

If you do not have above exemption, please continue through the following instructions and complete the form.

- Your application will need to include a written statement in support of the application, including any relevant information and documentation as evidence of the non-financial hardship which is preventing you from being able to make payment on this invoice.
- A range of payment instalment plan options are available to assist you in finalising your account. An instalment plan can be organised by calling our dedicated Customer Service Team on 1300 655 200.
- NSW Ambulance may not accept applications for a fee review if received more than 7 days after the due date specified on the debt notice. If you are applying for a fee review, you should submit your application prior to the due date.
- The supporting documentation that may be relevant for your application is listed in Section A of this document. If NSW Ambulance requests further documentation to support your application, this must be provided within 14 days of the request.
- The outcome is valid only for the invoice specified on the approved application. If your application is unsuccessful, you will remain liable for payment of the invoice and may be offered an instalment plan or payment deferral.

Section A	Documentation required (Do NOT send original documents, only copies)	
1	If applicable – official written notice from your case worker that you were under the Asylum Seeker Assistance Scheme (ASAS) and Community Assistance Scheme (CAS).	☐
2	If applicable – official written notice from a relevant organisation to confirm the patient was in the care responsibility or parental responsibility of the State, or under the care of a guardian receiving financial assistance as per the Children and Young Person's (Care and Protection) Act 1998.	☐
3	If applicable – a police report or hospital admission report (e.g. evidence of a Good Samaritan)	☐
4	*If applicable – a copy of the death certificate for the patient.*	☐
5	*If applicable – official written notice from the solicitor OR a statutory declaration completed by the Executor of the Estate/next of kin to advise that the patient did not hold any exemptions to cover the invoice. This must include official evidence of the relationship to the estate (i.e. Executor or next of kin).*	☐
6	*If applicable – an official letter of advocacy or a certificate from your treating doctor, social worker, mental health worker, charitable organisation case worker or other relevant person of authority.*	☐
	Please provide any other official documentation that you believe will support your application	

Section B Patient Details					
Family Name (Surname)		First Name			
Contact	Phone (daytime): Email:			Date of Birth	
Street address		Suburb		State & Post Code	
Name of Legal Guardian/s (if patient is a minor) Please note that under the Health Services Amendment (Ambulance Services) Bill 2015, a legal guardian is required to act on behalf of a minor for the purposes of this review.					

Section C Additional Information

Please describe any additional information that is relevant to include which is supplementary to the advice provided above

Section H Certification by applicant (to be signed in the presence of the witness)

I certify that:

1. I am the applicant.
2. I have read this application.
3. The facts in it that are within my personal knowledge are true.
4. All other facts are true to the best of my knowledge, information and belief.
5. I have disclosed all relevant financial information.
6. I am aware that it is an offence to provide information or a document in connection with this application that is false or misleading.

Signature of Applicant	*Place:*	*Date:*
Before me (signature of witness)	Full name of witness (please print)	

This application was prepared by: ☐ Applicant ☐ Lawyer ☐ Other

Print Details:

Please send your completed application to NSW Ambulance by one of the following methods:

Email: Ambulance-FinanceAccounts@health.nsw.gov.au	*Fax:* (02) 9320 7813
Mail: NSW Ambulance Locked Bag 14 Rozelle NSW 2039	Please call our dedicated Customer Service Team on 1300 655 200 for any enquiries you may have.