AHSA HIGH COST MEDICAL DEVICE APPLICATION FORM

Please complete all fields below and forward this application directly to the health fund concerned with as much notice as possible prior to the procedure date as the health fund may not agree to contribute after the procedure.

FACILITY INFORMATION		
Facility Name:		Provider No:
Contact Person:		Contact No:
Contact Email:		
PATIENT INFORMATION		
Patient's name:		Date of Birth:
Health Fund:		Membership No:
Date of Request:	Treating Doctor & Contact No:	Date of Procedure:
ITEM DETAILS		
Item Description: **Model Number:**		
INTENDED CHARGE:		**Quantity of item(s):**
Provisional DRG (if known):	MBS Number(s):	Intended Procedure:
Supplier Name: Supplier Contact Email/Ph No:		TGA/SAS Approval: ☐ TGA #_____ ☐ SAS ☐ No If SAS please attach copy of the certificate (if applicable)
Comparator Items, codes & charges: Please supply any relevant product information from suppliers outlining comparators.		
What are the clinical indications for this item? What clinical outcome benefits do you expect? *Please supply a letter from the doctor outlining patient's age, relevant medical conditions, reasons for choice, alternatives and expected outcome (i.e. clinical indicators).*		
Provider Declaration: • I declare that all the information provided in connection with this application is true and correct. Provider's Signature: Date:		

Disclaimer: This form is to be used when requesting payment for a medical device not listed on the Commonwealth Prostheses List. Please be aware that some items that are not on the prostheses list may be covered under other funding arrangements for example theatre bands and therefore not eligible for additional payment.