Australian Government
Department of Human Services

PBS

Claim and confirmation for Home Medicines Review service

Important information

This form is to be completed by the pharmacist conducting the Home Medicines Review (HMR) service and signed by the patient, carer or patient's legal guardian.

All claim and confirmation for HMR service forms must be submitted with a completed HMR claim cover sheet.

Assistance

If you need assistance completing this form or for more information about the HMR program email **sa.guild.govt.prog@medicareaustralia.gov.au** or call **08 8274 9641** (call charges will apply) between 8.30 am and 5.00 pm, Monday to Friday, Australian Central Standard Time.

Claim details

1 Claim reference number

2 Service number ☐ of ☐ in this claim submission

3 Full name of patient

4 Medicare or Repatriation Pharmaceutical Benefits Scheme number

☐☐☐☐ – ☐☐☐☐☐ – ☐ Ref no. ☐

5 Prescriber number of referring general practitioner

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

6 Full name of referring general practitioner

7 Date of referral

/ /

8 Reason for referral (**tick one only**)

Poly-pharmacy ☐
Suspected adverse event ☐
Using medicine with a low therapeutic range ☐
Other (please specify) ☐

9 Recommendation(s) to general practitioner (**tick all that apply**)

Increase in dose of one or more medicines ☐
Reduction in dose of one or more medicines ☐
Change of one or more medicines to a different medicine ☐
Cessation of one or more medicines ☐
Other (please specify) ☐

10 Full name of accredited pharmacist who conducted the HMR service

11 Accreditation number of accredited pharmacist who conducted HMR service

12 Date of service with patient

/ /

13 Location of service

Home ☐ ***Go to 15***
Other (please specify) ☐

14 Reason for conducting service outside the home:

Cultural ☐
Other (please specify) ☐

15 Postcode of HMR location

☐☐☐☐

Declaration

This section is to be completed by the patient, carer or legal guardian of the patient to confirm that this HMR service has been provided.

16 I declare that:

- my general practitioner and pharmacist have provided me with information regarding the HMR process
- I consent to my personal information being provided to, and collected by, an accredited pharmacist who is, or is employed by, an approved HMR service provider for the purposes of the HMR
- I consent to my personal information being gathered through the HMR, and its inclusion in the HMR clinical assessment report
- I consent to the HMR clinical assessment report being sent to my community pharmacy and HMR service provider and referring general practitioner
- the information on this form is correct.

17 I am the:

patient ☐

carer or legal guardian of the patient ☐

Patient, carer or legal guardian full name

Patient, carer or legal guardian signature

Date

/ /

Privacy note

The information provided on this form will be used to confirm that an HMR service was provided to you by a pharmacist. The collection of this information is authorised by the *Human Services (Medicare) Act 1973.* This information will be provided to the Department of Human Services to determine payments to the HMR service provider claiming benefit under the HMR program and may be disclosed to the Department of Health and Ageing, Department of Veterans' Affairs, or as authorised or required by law.

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