Australian Government
Department of Human Services

medicare

PBS

Claim and Confirmation for Home Medicines Review Service

When to use this form

This form is to be completed by the accredited pharmacist conducting the Home Medicines Review (HMR) service in the patient's home.

If the HMR Service is conducted outside the patient's home, then prior approval must be sought from by the Department of Health and Ageing and your prior approval number must be included in this form.

This form must be signed by the patient, carer or patient's legal guardian and the accredited pharmacist conducting the review.

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

For more information

For more information about the HMR program or if you need assistance completing this form email **sa.guild.govt.prog@medicareaustralia.gov.au** or call **08 8274 9641** Monday to Friday, between 8.30 am and 5.00 pm, Australian Central Standard Time.
Note: Call charges apply – calls from mobile phones may be charged at a higher rate.

Returning your form

Check that you have answered all the questions you need to answer and that you have signed and dated this form.

Community Pharmacy Agreement Officer
Pharmaceutical Benefits Branch
Department of Human Services
GPO Box 9826
ADELAIDE SA 5001

Filling in this form

- **Please use black or blue pen**
- Print in BLOCK LETTERS
- Mark boxes like this ☐ with a ✓ or ✗
- Where you see a box like this ☐ ***Go to 5*** skip to the question number shown. You do not need to answer the questions in between.

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 Full name of accredited pharmacist who conducted the HMR service

10 Accreditation number of accredited pharmacist who conducted HMR service

11 Prior approval number for registered pharmacist who conducted the HMR service

Approval date
/ /

Note: Service must be provided by the accredited pharmacist in the patient's home unless prior approval has been granted. Services that do not meet the requirements of the Program Specific Guidelines will not be paid.

Attach evidence that prior approval has been granted for the HMR service to be conducted by a registered pharmacist.

12 Date of service with patient

/ /

13 Time of appointment with patient

14 Location of service

Patient home ☐ Patient home suburb

Patient home postcode

Other (**must** specify) ☐

Prior Approval number for service to be conducted outside the home

Approval date

/ /

Note: Service must be provided at the patient's home unless prior approval has been granted. Services that do not meet the requirements of the Program Specific Guidelines will not be paid.

Attach evidence that prior approval has been granted for the HMR service to be conducted outside the home.

15 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) ☐

Accredited pharmacist declaration

This section is to be completed by the accredited pharmacist conducting the Home Medicines Review.

16 **I understand that**:

- giving false or misleading information is a serious offence.

I declare that:

- I have read and acknowledge the Medication Management Review Terms and Conditions, the Fifth Community Pharmacy Agreement General Terms and Conditions and the Home Medicines Review Program Specific Guidelines
- I have conducted this Home Medicines Review service in accordance with the Medication Management Review Terms and Conditions, the Fifth Community Pharmacy Agreement General Terms and Conditions and the Home Medicines Review Program Specific Guidelines
- I have conducted this Home Medicines Review service in the patient's home or outside the patient's home with prior approval
- I have sent the Home Medicines Review report to the patients nominated community pharmacy
- I have given permission for my details included on this form to be provided to the Department of Human Services and any other relevant authority
- where required, I have attached evidence that prior approval has been granted for the Home Medicines Review service to be conducted by a registered pharmacist
- I have received a copy of the ***Medication Management Review Programs Terms and Conditions*** (**4718**)
- the information provided in this form is complete and correct.

Full name of accredited pharmacist who conducted the review

Signature of accredited pharmacist who conducted the review

Date

/ /

Patient, carer or legal guardian declaration

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

17 I declare that:

- the information provided in this form is complete and correct.
- my referring general practitioner and accredited pharmacist have provided me with information regarding the Home Medicines Review process including that I have the choice of which accredited pharmacist conducts my Home Medicines Review at my home.

I consent to:

- my personal information being provided to, and collected by, an accredited pharmacist who is, or is employed by, an approved Home Medicines Review service provider for the purposes of the Home Medicines Review
- my personal information being gathered through the Home Medicines Review, and its inclusion in the Home Medicines Review clinical assessment report
- the Home Medicines Review clinical assessment report being sent to my referring general practitioner, Home Medicines Review service provider, my community pharmacy and general practitioner.

I understand that:

- giving false or misleading information is a serious offence.

I am the:

patient ☐
carer of the patient ☐
or
legal guardian of the patient ☐

Patient, carer or legal guardian full name

Patient, carer or legal guardian signature

Date

/ /

Privacy notice

Centrelink, Medicare, Child Support and CRS Australia are services within the Australian Government Department of Human Services (Human Services).

Your personal information is protected by law, including the *Privacy Act 1988*. Your information is collected for Social Security, Family Assistance, Medicare, Child Support and CRS purposes. This information may be required by the powers provided within each services' legislation or voluntarily given by you when you apply for services or payments.

Your information will be used for the assessment and administration of payments and services. Your information may also be used within Human Services, where you have provided consent or it is required or authorised by law. Human Services may disclose your information to Commonwealth Departments, other persons, bodies or agencies ONLY where you have provided consent or it is required or authorised by law.

You can get more information about privacy by going to our website **humanservices.gov.au/privacy** or requesting a copy of the full privacy policy at one of our Service Centres.