Tax Invoice

COVID-19 Vaccine Payment

For patients who are not eligible for a Medicare Card

COORDINARE Ltd
ABN: 27 603 799 088
PO Box 325
FAIRY MEADOW, NSW 2519

Email completed form to
rjohnson@coordinare.org.au

This form is to be used when requesting a payment for the provision of GP/OMP services to administer COVID-19 vaccines to patients who do not have a valid Medicare Card or are not eligible for a Medicare Card.

DATE:		**PRACTICE NAME:**		**ABN:**	

CLAIM DETAILS			
FOR THE PERIOD (DATE) FROM…….. TO…….			
RELEVANT MBS ITEM NUMBER	**REBATE AMOUNT**	**NUMBER OF SERVICES CLAIMED**	**AMOUNT CLAIMED ($)**
93644	$36.55		$
93645	$40.10		$
93646	$29.30		$
93647	$36.25		$
93653	$49.55		$
93654	$53.00		$
93655	$39.95		$
93656	$46.60		$
93660	$22.25		$
93661	$25.40		$
90005	$123.00		$
10660	$41.40		$
10661	$33.15		$
FEE	**AMOUNT PER NON-MBS PATIENT VACCINATED**	**NUMBER OF PATIENTS CLAIMED**	
ADDITIONAL SUPPORT/CLERICAL STAFF COST	$100.00		$
		TOTAL CLAIM	**$**

PLEASE ENSURE PAYMENT DETAILS AND DECLARATION OVERLEAF ARE COMPLETED PRIOR TO SUBMISSION

IT IS MANDATORY THAT ALL IMMUNISATIONS BE REPORTED TO THE AUSTRALIAN IMMUNISATION REGISTER (AIR). PLEASE INDICATE HERE THAT THE IMMUNISATIONS BEING CLAIMED FOR HAVE BEEN ENTERED INTO AIR.
YES ☐

PAYMENT DETAILS	
BANK:	
BSB:	
ACCOUNT NUMBER:	
ACCOUNT NAME:	

DECLARATION	
I HEREBY DECLARE THAT THE INFORMATION CONTAINED WITHIN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT A FALSE STATEMENT MAY DISQUALIFY ME FOR PAYMENTS.	
NAME:	
POSITION:	
SIGNATURE:	
DATE:	