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 CVCP 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:		**PHARMACY NAME:**		**ABN:**	

CLAIM DETAILS			
FOR THE PERIOD (DATE) FROM…….. TO……..			
RELEVANT ITEM	**REBATE AMOUNT**	**NUMBER OF SERVICES CLAIMED**	**AMOUNT CLAIMED ($)**
MM1 FEE	$27.50		$
MM2-7 FEE	$30.65		$
SITE VISIT PAYMENT	$123.00		$
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.*** • ***CLAIMS MADE TO COORDINARE FOR THESE PAYMENTS REPLACE CLAIMS THAT WOULD OTHERWISE HAVE BEEN MADE TO THE COVID -19 VACCINATION IN COMMUNITY PHARMACY PROGRAM, AND ARE <u>NOT</u> IN ADDITION TO THEM.***

NAME:	
POSITION:	
SIGNATURE:	
DATE:	