

SAMPLE APPLICATION FOR 2ND TIER DEFAULT BENEFIT ELIGIBILITY

An industry-based Second Tier Benefits Advisory Committee (the Committee) assesses applications from private hospitals and day surgeries and makes recommendations to the Minister for Health and Ageing on the eligibility of applicants to receive the benefit.

The Committee has expressed concern that some hospitals and day surgeries are submitting large quantities of unnecessary and irrelevant information, when the evidence required to be submitted is relatively straightforward. The Australian Private Hospitals Association, in consultation with the Committee, has prepared the following sample application for 2nd tier default eligibility to assist those facilities wishing to apply for 2nd tier eligibility.

The application includes samples of the evidence required by the Committee in order for hospitals and day surgeries to demonstrate compliance with the 2nd tier eligibility criteria. The comments in italics provide further information about the evidence required. In addition, applicants should:

- ✍ Only provide what is necessary (ie there is no need for extraneous or additional material);
- ✍ Ensure you provide what is necessary (ie include evidence that you meet *each* criterion);
- ✍ Understand the requirements for:
 - Informed Financial Consent
 - Simplified Billing

Before applying for 2nd tier eligibility, facilities should first familiarise themselves with the document “**Administrative Arrangements for the Second Tier Default Benefits for Overnight and Day Only Treatment**” which is attached to Department of Health and Ageing Circular PHI 41/08 of 14 August 2008. A copy of this circular and the attachment is available in the *2008 Private Health Insurance (PHI) Circulars* area of the Department’s website at:

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-phicirculars2008-41_08.htm

Meetings of the Committee are held quarterly to consider applications for 2nd tier eligibility. Meeting dates and deadlines for submitting applications are advised through *APHA Vital Signs*.

Meeting date and deadline information, as well as updates on which hospitals are eligible for Second tier default benefits under Schedule 5 of the *Private Health Insurance (Benefit Requirements) Rules* (the PHI Rules), are also advised via Department of Health and Ageing PHI Circulars. These circulars include links to the most recent version of the PHI Rules listed on the ComLaw website. If you do not receive PHI Circulars, you may wish

to contact the Department at the following email address: PrivateHealth@health.gov.au and request to be added to the email distribution list.

Please note that applicants are required to **submit nine (9) stapled copies** of their application to:

Secretariat
Second Tier Advisory Committee
c/o Australian Government Department of Health and Ageing
MDP 86
GPO Box 9848
CANBERRA ACT 2601

Please note you will need to provide at least **two (2) copies of a covering letter** with your application which should include appropriate contact details of the person responsible for the application including name, position title, postal address and email address.

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Attachments

1. State Licence
2. Commonwealth Provider Number
3. Accreditation certificate
4. Sample of simplified billing
5. Informed Financial Consent Form
6. Hospital Casemix Protocol

Attachment 1 – State Licence

Comments

You must attach a current copy of your hospital's state licence or registration to satisfy this criterion.

LICENCE

Private Hospitals and Day Procedure
Centres Act 1988

The establishment known as:
XYZ Private Hospital

Located at:
123 Hospital Road

is hereby licensed as a:

Day Procedure Centre

This licence is issued to:

Mr Joe Bloggs

Licence No: **DC155**

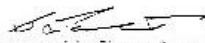
Of:
123 Hospital Road

The class(es) in respect of which this licence is
issued is(are):

Surgical

The maximum number of patients who may be
lodged at any one time is:

This licence is subject to the the conditions set
out in the Schedule hereto and remains in force
until cancelled by the Director-General.


Delegate of the Director-General

6 August 1996

Date of Issue

Attachment 2 – Commonwealth Provider Number

036594X

Comments

You must quote your hospital's Commonwealth Provider Number to satisfy this criterion.

*Please note that your Commonwealth Provider Number must be included within **each** copy of your application. At times, facilities have only included the Commonwealth Provider Number in the covering letter accompanying their applications – unfortunately on some occasions the Committee do not receive this single covering letter and therefore do not receive a vital component of your application requirements.*

Attachment 3 – Accreditation certificate

Comments

The Private Sector Quality Criteria have been incorporated into general accreditation requirements since 1 July 2003. Therefore if your facility has been accredited since that date, attaching a copy of your current accreditation certificate will satisfy the requirement of this criterion.

*If your last accreditation survey was prior to 1 July 2003, **in addition** to attaching a copy of your current accreditation certificate, you will **also** need to obtain a letter from your accrediting organisation confirming that your facility complies with the Private Sector Quality Criteria.*

*Similarly if your accreditation agency is not an ‘industry approved and accredited accreditation agency, **in addition** to attaching a copy of your current accreditation certificate, you will **also** need to attach a copy of a certificate confirming that your facility complies with the Private Sector Quality Criteria from an ‘industry approved and accredited accreditation agency’.*

Please note that only “industry approved and accredited accreditation agencies” can assess facilities against the Private Sector Quality Criteria. A list of these approved accreditation agencies is available from Mr Peter Callanan in the Private Health Insurance Branch of the Department of Health and Ageing.



ACCREDITATION CERTIFICATE

This is to certify that
The Australian Council on Healthcare Standards
has accredited

XYZ Private Hospital

This certificate is granted by the authority of the Council in recognition of the achievement of Evaluation & Quality Improvement Program (EQulP) standards and a commitment to continuous improvement in the quality of care, service and safety when surveyed in

March 2001

On this basis ACHS Accreditation is awarded subject to continuous evaluation and quality improvement until

29 May 2005

A handwritten signature in cursive script, appearing to read 'G. Smith'.

President

A handwritten signature in cursive script, appearing to read 'R. Jackson'.

Chief Executive

Attachment 4 – Sample Bill demonstrating hospital and medical simplified billing

Comments

HOSPITAL

Attaching a de-identified patient account demonstrating that all hospital services are contained in a single account will satisfy the hospital simplified billing requirement.

MEDICAL

Please note that for medical simplified billing, hospitals are only required to demonstrate they “have processes in place that would allow the inclusion on in-hospital medical bills in a simplified billing arrangement.” Therefore, it is not necessary to actually be undertaking medical simplified billing on a regular basis, merely to have the capacity to do so.

Compliance with the medical simplified billing requirement of this criterion can be demonstrated in one of the following ways:

- ✍ Attaching a de-identified hospital account that includes amounts for medical bills (as per attached example)*

- ✍ Providing written advice from a software vendor that the billing systems used in your hospitals have the capacity to include medical bills in the hospital account.*

XYZ Private Hospital

MEDIBANK PRIVATE
GPO BOX 9999
SYDNEY 2001

DUPLICATE INVOICE OF FEES ABN 91 623 837 539

Issued 5/ 4/ 02

Patient: Mrs JOSEPHINE MARY BLOGGS
Admitted: 13/ 12/ 01
Medicare: 1231231231

File No: PSEUDO#
Discharged: 13/ 12/ 01

Date	Item	Description	Amount
13/12/01		Accommodation Fee - Band 3	300.00
	45659	Correction of Bat Ear	600.00
	45659	Correction of Bat Ear	200.00
		Start time 800, End time 925	
13/12/01		Dr. J. Briedis, Provider 0016325L: 14 Kensington St. Kogarah - SURGEON	0.00
	45659	Correction of Bat Ear	1360.00
	45659	Correction of Bat Ear	0.00
13/12/01		Dr. P. James Provider 048733Y: 57A Montgomery St., Kogarah - ANAESTHETIST	0.00
	0	Anaesthetist's fee for operation	608.70
	0	Pre-operative consultation [separate attendance]	0.00

		Total Fees	3068.70Dr

PAYMENT SLIP

Please include this slip when paying your account.

CREDIT CARD PAYMENT Bankcard Mastercard Visa

Card Number _____ / _____ / _____ / _____ Expiry Date ____ / ____

Amount Paid _____ Signature _____

Cardholder name _____

Mrs J Bloggs
1 Little Street
Little Town 1001

Invoice Date 5/ 4/ 2002

Total Amount Due \$ 3068.70

Attachment 5 – Informed financial consent form.

Comments

To demonstrate compliance with this criterion, you must attach a copy of the informed financial consent form used by your hospital. The informed financial consent form attached to your application may be de-identified or a dummy example, but must include actual dollar amounts to demonstrate that hospital staff understand how to provide informed financial consent using the form (see attached example).

To comply with Informed Financial Consent requirements, the form must detail in writing the following:

- 1. the hospital charges (in \$ amounts)*
- 2. the Health Insurer benefit (in \$ amounts)*
- 3. any out of pocket costs (in \$ amounts)*
- 4. a space for the patient (or nominee) signature – confirming that they have been informed of, and understand the charges*

*It is **not sufficient** to show **only** the out of pocket costs. Informed financial consent requires that the patient is informed of both the actual hospital charges and actual insurer benefits – even where there is no gap.*

It is acceptable to state that the costs shown are estimates only and may vary according to the length of stay, type of procedure actually performed etc. It is also acceptable to illustrate those out of pocket expenses that are Insurer agreed excesses and co-payments. The form may include a statement outlining the charges that are not billed by the hospital for which a patient may receive a separate account.

XYZ Private Hospital – Estimate for Hospital Services

Facility Information

Facility Name Facility Provider Number
 Contact Officer Contact Number

Patient Information

Patient surname Given name
 Patient's Address
 Post Code
 Patient's telephone

Date of Birth Patient Sex Male Female
 Patient's health insurance fund Membership Number
 Fund Table Membership Verification Number
 Date joined Fund excess \$

Procedure Details

Date of Admission 23/6/02

Procedure	Item Number	Bed Charge	Anticipated days to be claimed (if per diem)
Lap. Chole	50455	\$550	1

Hospital Quotation

Hospital Fees		Estimated cost	Fund rebate	Patient cost
Accommodation		\$500	\$500	\$50
Theatre		\$2000		
Consumables		\$200		
Other		\$50		
Fund excess		\$2800		
Total				\$300

Patient / Guardian to complete

Certification

I, (insert name) _____
 The patient or nominee named herein undertake to pay the patient payment as indicated, together with any unforeseen costs which may arise as a consequence of the procedure(s).

Signature Date

Attachment 6 – Hospital Casemix Protocol

Comments

To meet this criterion, applicants should include as part of their application a statement regarding whether or not their facility is able to provide hospital casemix protocol data to funds electronically (preferably by disk, CD, or e-mail), with claims.