PTSS APPEAL FORM

Patients are able to appeal the outcome of their Patient Travel Subsidy Scheme (PTSS) Application. **All enquiries about the PTSS, including appeals, must be forwarded to the patient's nearest public hospital.**

Further information about assistance provided under the PTSS is available from any Hospital and Health Service (HHS), Community Health Centre and the PTSS website *http://www.health.qld.gov.au/ptss*

How to appeal:

- Appeals should be lodged with your nearest hospital no more than 30 days from the date you were notified of the application outcome.
- The PTSS Approver at your nearest hospital shall hold the discretion on accepting appeals lodged more than 30 days from the date of notification.
- Your appeal will be assessed within five (5) working days from date of lodgement. Appeals may take longer if additional information or documentation is required.
- Your appeal will be assessed in the same manner as the original PTSS Application. That is, the same eligibility criteria and requirements still apply. However, the PTSS Approver shall take into consideration any new or supporting information provided as part of the appeal.

SECTION A – PATIENT INFORMATION *(to be completed by the patient or guardian)*

Title:	Family name:	Given name(s):	DOB:
Residential address:			
Postal address *(if different)*:		Mobile phone:	
Email address:		Home phone:	
Preferred contact method: ☐ Phone ☐ Email ☐ Mail			

SECTION B – APPEAL INFORMATION *(to be completed by the patient or guardian)*

1. Appeal relates to:

Patient : ☐ Travel subsidy ☐ Accommodation subsidy	Escort: ☐ Travel subsidy ☐ Accommodation subsidy
Application non-approval date *(as indicated on non-approval notification)*:	

2. Reasons for appeal:

If you have received notification of non-approval of a PTSS Application, please refer to the reason/s for non-approval given and respond. If you need more space, please attach extra pages and all relevant documents to support your appeal.

3. Patient Declaration:

The information that I have provided is true and accurate at the time of appeal. I give my permission for hospital staff to obtain information about my medical condition for the purposes of this appeal; to forward relevant details regarding my application to the treating hospital, transport and/or accommodation provider or other relevant party as is required.

Signature of Patient/Carer or Guardian	Name of Patient/Carer/Guardian (please print)	Date

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SECTION C – APPEAL ASSESSMENT *(to be completed by approving officer – admin use only)*

PTSS ID No.:	Cost Centre:

Patient name:	DOB:
Address:	

4. Appeal received by:

Name:	Position:
Signature:	Date:

5. Appeal assessed by:

Name:	Position:
Signature:	Date:

6. Patient notified of Appeal outcome:

Name:	Position:
Signature:	Date:
Patient notified of appeal outcome: ☐ Phone ☐ Email ☐ Mail ☐ In person	Date:

7. Appeal outcome/comments:

☐ **PTSS Approved**	Approved patient mode of travel: ☐ Bus ☐ Rail ☐ Air ☐ Private Motor Vehicle ☐ Other (provide details):	Approved escort mode of travel: ☐ Bus ☐ Rail ☐ Air ☐ Private Motor Vehicle ☐ Other (provide details):
Is Accommodation approved? ☐ Yes ☐ No	From:	To: