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 in 2024** 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	$28.35		$
MM2-7 FEE	$31.60		$
SITE VISIT PAYMENT	$127.30		$
FEE	**AMOUNT PER NON-MBS PATIENT VACCINATED**	**NUMBER OF PATIENTS CLAIMED**	
ADDITIONAL SUPPORT/CLERICAL STAFF COST	$100.00		$
		TOTAL CLAIM	**$**

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 NOT IN ADDITION TO THEM.***

NAME:	
POSITION:	
SIGNATURE:	
DATE:	