Tax Invoice

Residential aged care facility or Disability housing
COVID-19 vaccination in-reach clinic

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 additional costs associated with providing **a minimum of ten (10) COVID-19 vaccinations to residential aged care or disability housing residents/staff at a single in-reach clinic (claims can only be for clinics held in 2024)**.*

General Practices are expected to claim the relevant funding for COVID-19 assessment and vaccination through existing mechanisms (i.e. MBS funding item or equivalent) where applicable.

DATE OF CLAIM		**PRACTICE NAME**		**ABN**	

NAME OF FACILITY WHERE TEN (10) OR MORE COVID-19 VACCINATIONS WERE GIVEN	
DATE OF CLINIC (MUST HAVE BEEN HELD IN 2024)	
NUMBER OF RESIDENTS GIVEN A COVID-19 VACCINATION AT THE IN-REACH CLINIC	
NUMBER OF STAFF GIVEN A COVID-19 VACCINATION AT THE IN-REACH CLINIC	
CLAIM AMOUNT EXC. GST	**$3,000.00**
GST 10%	**$300.00**
TOTAL CLAIM INC. GST	**$3,300.00**

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:	
REGISTERED FOR GST:	☐ YES ☐ NO

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:	