Queensland Government

Patient Travel Subsidy Scheme (PTSS)

SPECIALIST CERTIFICATION FORM

SECTION A – CERTIFICATION BY SPECIALIST *(specialist completes)*

This form is for the applicant's treating specialist to complete to verify that the specialist treatment was received, and to notify the HHS of any further treatment requirements. The form is signed at the end of each treatment block, with unused rows crossed out. A separate Specialist Confirmation Form should be used for each specialist seen by the patient, or for different treatment periods. Patients seeking part payment during treatment should submit a completed and signed form and begin a new form.

PTSS ID Number:	PTSS Claim Number:	PTSS Application Number:

Patient Name:	DOB:	Address:
Specialist Name:		Address:
Specialty:		Email:
Provider Number:		Phone:

SECTION B – SINGLE TRIP SPECIALIST TREATMENT *(specialist completes)*

1. Patient received specialist treatment? ☐ Yes ☐ No			
Date from:	Date to:	Appointment type:	☐ Inpatient ☐ Outpatient
2. Excluding hospitalisation, was it a medical necessity for the patient to stay overnight/s?			☐ Yes ☐ No
Date from:	Date to:	Was Telehealth available?	☐ Yes ☐ No

3. Has the patient's treatment been completed? ☐ Yes *(Patient is returning home – complete this section only)* ☐ No *(Complete Section C)*	
Patient return home date: Patient return home time:	*If interim claims for reimbursement will be made, the treating specialist will be required to certify treatment provided by completing Section C of this form for each interim claim.*

4. Does the patient have any special travel arrangements?			5. Mode of patient transport	
☐ None	☐ Stretcher	☐ Wheelchair	☐ Bus	Clinical reason for air travel:
☐ Oxygen	☐ Other:		☐ Rail	
Escort mode of transport?			☐ Air Travel	
☐ Bus ☐ Rail ☐ Air Travel	☐ Private vehicle		☐ Private vehicle	
☐ Other:			☐ Other:	

SECTION C – ONGOING SPECIALIST TREATMENT *(specialist completes after each appointment)*

6. Diagnosis or nature of ongoing treatment:

7. Ongoing treatment details: ***Please note: All travel must be pre-approved by the patient's local hospital.*** *Cross out or delete unused rows prior to final signature. Entries made on this form after the date of the specialist signature may not be processed.*

Date From	Date To	Accomm. Required	Telehealth Available	Treatment Type	Escort Required	Next Appointment Date	Appointment type	Treatment Location	Specialist Initial & Date
		Yes / No	Yes / No	☐ Diagnosis ☐ Treatment ☐ Review	Yes / No	/ /	☐ Inpatient ☐ Outpatient		/ /
		Yes / No	Yes / No	☐ Diagnosis ☐ Treatment ☐ Review	Yes / No	/ /	☐ Inpatient ☐ Outpatient		/ /
		Yes / No	Yes / No	☐ Diagnosis ☐ Treatment ☐ Review	Yes / No	/ /	☐ Inpatient ☐ Outpatient		/ /
		Yes / No	Yes / No	☐ Diagnosis ☐ Treatment ☐ Review	Yes / No	/ /	☐ Inpatient ☐ Outpatient		/ /
		Yes / No	Yes / No	☐ Diagnosis ☐ Treatment ☐ Review	Yes / No	/ /	☐ Inpatient ☐ Outpatient		/ /

Continue to page 2 (If additional appointments are required, please attach confirmation details)

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8. Does the patient have any special travel arrangements?			9. Mode of patient transport	
☐ None	☐ Stretcher	☐ Wheelchair	☐ Bus	Clinical reason for air travel:
☐ Oxygen	☐ Other:		☐ Rail	
Escort mode of transport?			☐ Air Travel	
☐ Bus ☐ Rail ☐ Air Travel ☐ Private vehicle			☐ Private vehicle	
☐ Other:			☐ Other:	

SECTION D – DECLARATIONS

Specialist Declaration:

I certify that the information in this form is correct and has been completed by me. I give my permission for the approving hospital's Medical Superintendent to contact me regarding my certification of the patient's treatment.

Specialist signature:	Specialist name:
	Date: / /

Patient Declaration:

By signing this form, I certify that the information on this form is correct and that all expenditure claimed was actually incurred and related to the provision of my healthcare. I acknowledge that claims may not be paid without accompanying receipts/tax invoices.

Patient signature:	Patient name:
	Date: / /

PATIENT TO ATTACH ALL TRAVEL RECEIPTS / TAX INVOICES WHEN SUBMITTING THIS FORM

SECTION E – ASSESSMENT & APPROVAL *(to be completed by approving officer – admin use only)*

Is specialist care available via Telehealth? ☐ Yes ☐ No ►	Comments:
Patient/escort receipts and invoices sighted? ☐ Yes ☐ No ►	
Specialist HHS? *(the HHS where the Specialist service is located):* ►	

☐ **PTSS Approved**:	Approval period: ☐ Single treatment	☐ Ongoing: Weeks: Months:
Patient Travel ☐ Yes ☐ No ► *Comment below*		Patient accommodation ☐ Yes ☐ No ► *Comment below*
Escort Travel ☐ Yes ☐ No ► *Comment below*		Escort accommodation ☐ Yes ☐ No ► *Comment below*
Approved mode of travel: ☐ Bus ☐ Rail ☐ Air ☐ Private Motor Vehicle ☐ Other:		

Name of PTSS approving officer:	Position:
Signature:	Date: / /

Name of Medical Superintendent/Delegate: *I authorise this travel/accommodation as medically required*	Signature:	Date: / /
Name of officer with financial delegation: *I authorise expenditure incurred for this application*	Signature:	Date: / /
Comments:		

☐ **PTSS Not Approved** *Provide reasons for non-approval* ►