Australian Government
Department of Health

National Epidermolysis Bullosa Dressing Scheme

Application Form

Quick Eligibility Check

If any of the following points apply, you are NOT eligible for the National Epidermolysis Bullosa Dressing Scheme, so please do not complete this Application Form.

- You are NOT an Australian citizen or permanent Australian resident
- You do NOT have suspected or confirmed Epidermolysis Bullosa
- Your sub-type of Epidermolysis Bullosa is NOT covered by the Scheme*

***Refer to the Eligibility Guidelines for more details or call the National Epidermolysis Bullosa Dressing Scheme Helpline on 1300 290 400 or visit www.ebdressings.com.au for assistance.**

Please return completed application to:

NEBDS Administrator
c/- BrightSky Australia
PO Box 6347
Silverwater DC NSW 1811

"NEBDS" stands for National Epidermolysis Bullosa Dressing Scheme
If you or your patient are already on NEBDS, and are having a review, please use only a NEBDS Review Form

SECTION 1 - Applicant's Particulars

1 Please complete using a blue or black pen.

Mark boxes like this ☑ or ☐ with a ✓.

If the box looks like this ☐ follow the instructions after the arrow.

If it has an instruction such as ***Go to 12***, skip to the question number shown. You do not need to answer the questions in between.

2 Are you the applicant or are you completing the form on behalf of the applicant?

I am the applicant and am 16 years of age or over ☐ ***Go to 6***

I am filling in the form on behalf of the applicant ☐ *Go to next question*

3 What is your relationship to the applicant?

Applicant's parent/legal guardian ☐
Applicant's carer ☐
Case manager ☐
Healthcare professional ☐
Other ☐ Specify below

4 Applicants can nominate someone else to be the main contact and to receive correspondence on their behalf. Has the applicant nominated you or someone else to be the main contact?

No ☐ Applicant to receive all NEBDS correspondence ***Go to 6***

Yes ☐ *Go to next question*

5 **Please give the name and contact details of the person nominated by the applicant to be the main contact.**

Name

Address

Suburb

State Postcode

Phone number ( )

Email (optional)

6 ***Please read this before proceeding***

The remainder of the questions in Section 1 are about the applicant. Words such as 'you' and 'your' refer to the applicant; not the person completing the form on the applicant's behalf.

Your name

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family Name

Given Names

7 Date of birth (dd/mm/yyyy)

/ /

8 Your sex: Male ☐ Female ☐

9 Your Medicare No.

☐☐☐☐ / ☐☐☐☐☐ / ☐ / ☐

To prove your Medicare eligibility, please attach a copy of your Medicare card.

10 Your contact details

Phone number ( )

Alternative phone number ( )

Email

11 Where do you live? *(your permanent address)*

Suburb

State Postcode

12 Address for product delivery (*if different from where you live*)

Suburb

State Postcode

13 Will someone confirm orders for NEBDS products and receive during business hours on your behalf?

No ☐ Go to next question

Yes ☐ Provide details below. If same as person in Question 5, go to next question.

Name of person

Relationship of the person to you

Phone number ( )

14 Are you a past recipient of NEBDS?

No ☐ ***Go to 16***

Yes ☐ Go to next question

15 Has your address changed since your last NEBDS application?

No ☐

Yes ☐ *What was your previous address?*

State Postcode

16 PRIVACY AND YOUR PERSONAL INFORMATION

- Your personal information is protected by law, including the *Privacy Act 1988*, and is being collected by BrightSky Australia on behalf of the Department of Health to determine your eligibility for the National Epidermolysis Bullosa Dressing Scheme.
- If you do not provide this information, the Department of Health may not be able to have the necessary information to make a decision on your eligibility for NEBDS.
- You can get more information about the way in which BrightSky Australia and Department of Health will manage your personal information, including the Department's privacy policy at www.health.gov.au/internet/main/publishing.nsf/Content/eb-dressing-1 and www.ebdressings.com.au

17 APPLICANT DECLARATION

I declare that the information provided in this form is correct and copies of both sides of my Concession Card (if applicable) and my Medicare card are attached.

If this Application is approved, I agree to:

- The delivery and co-payment terms and conditions of the Scheme as outlined in the National Epidermolysis Bullosa Dressing Scheme booklet.
- Making the co-payments to BrightSky Australia at the time of ordering.
- Attend a regular review with my Treating Healthcare Professional as directed, or risk being removed from the Scheme.

I consent to BrightSky Australia collecting health information about me for the purpose indicated above.

Signature of Applicant (if 16 years and over) or Authorised Person.

Date: / /

SECTION 2 - Health Report National Epidermolysis Bullosa Dressing Scheme

This section must be completed by the referring EB Specialist

Instructions for Health Professional

H1 ☐ I am familiar with the NEBDS Eligibility Guidelines and consider this patient meets the criteria.

You should only complete this Health Report if you are in a position to make an accurate assessment of the applicant in relation to their suspected epidermolysis bullosa condition.

If in doubt, contact the NEBDS Helpline on 1300 290 400 for further information.

H2 Name of applicant

Family Name

Given Names

H3 Applicant's date of birth (dd/mm/yyyy)

/ /

H4 Name of Health Professional (first & last name)

Title Dr ☐ Mr ☐ Assoc/Prof ☐ Prof ☐

H5 Your contact details (physician label, stamp accepted)

Provider number

Phone number ( )

Mobile phone number

Fax number ( )

Email

Insert physician label here (if applicable).

H6 Health Professional address for correspondence

Suburb

State Postcode

H7a Suspected EB type and subtype:

☐ Simplex ☐ Junctional
☐ Dystrophic ☐ Kindler
☐ Subtype: _____

H7b How has the diagnosis been made? (tick all that apply)

☐ Clinical: ***Go to H8***
☐ Skin biopsy
  ☐ Results not available: ***Go to H9***
  ☐ Results attached: ***Go to H11***
☐ Genetic test
  ☐ Results not available: ***Go to H9***
  ☐ Results attached: ***Go to H11***

H8 Provide explanation of clinical diagnosis

_____

_____

H9 If diagnostic results are not available, please state reasons

_____

_____

H10 Please indicate the expected date that results will be available

/ /

H11 The Applicant's next review date is

☐ 3 months
☐ 6 months
☐ 9 months
☐ 12 months from application acceptance
☐ 12 months from birth date

* All patients must have a nominated review date (which must be attended), or risk being removed from the Scheme.

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- If you do not provide this information, the Department of Health may not be able to have the necessary information to make a decision on your patient's eligibility for NEBDS.
- You can get more information about the way in which BrightSky Australia and Department of Health will manage your personal information, including the Department's privacy policy at www.health.gov.au/internet/main/publishing.nsf/Content/eb-dressing-1 and www.ebdressings.com.au

HEALTH PROFESSIONAL DECLARATION

I declare that the information provided in the Health Report is correct.

Signature of Health Professional

Date: / /

Please continue to Section 3 on page 4.

SECTION 3 - Dressings - (refer to schedule of products)

To be completed by the treating Nurse or EB Specialist to advise of best estimate of monthly dressing requirements for the Applicant.

Applicant's Name: _____

BrightSky Product Number	Brand	Product Description	Size	Quantity	State box, carton, piece or each

Note that products not listed on the Schedule of Dressings are not subsidised under the Scheme.

Please attach additional page if required.

☐ I have advised the Applicant on the most appropriate dressings and how they are to be applied.

HEALTH PROFESSIONAL DECLARATION

I declare to the best of my knowledge that the dressings listed are the best estimate of the Applicant's requirements for one (1) month's use and are the most suitable dressing for treating this condition for this Applicant.

Signature of Nurse or EB Specialist

Date / /

Send the completed Application Form, which includes the Health Report and, a copy of both sides of the Concession Card (if required) to:

NEBDS Administrator
c/- BrightSky Australia
PO Box 6347
Silverwater DC NSW 1811
Fax: 1300 88 66 02
Email: eb@brightsky.com.au

*This section will not be used in the assessment of the application.

NEBDS910
03 2014