

# NSW Medical Energy Rebate



## Application form: Retail Customers

### Applicant details

The applicant must be the primary account holder of the electricity account and must be at the applicant's primary place of residence. A new completed application form must be submitted to your retailer every year or if there are changes to the patient's circumstances.

|   |  |
|---|--|
| <b>First Name:</b>                      |  |
| <b>Last Name:</b>                       |  |
| <b>CRN or DVA Number:</b>               |  |
| <b>Electricity Account Number:</b>      |  |
| <b>National Meter Identifier (NMI):</b> |  |

Your NMI can be found on your electricity bill. It starts with 4 and is 11 digits long with no letters or symbols.

### Applicant declaration and authorisation statement

I understand that:

- My energy retailer will use Centrelink Confirmation eServices to verify my eligibility for the rebate.
- It is my responsibility to ensure that all the information provided in this application is, to the best of my knowledge, true and correct and I will notify my energy retailer of any changes to my information.
- I may be required to provide additional information about my eligibility.
- I can only receive the NSW Medical Energy Rebate once per financial year.
- I must have consent from the patient to use and disclose their details for the purpose of this application.
- By signing this document, I can confirm that I have read and understood my energy retailer's privacy notice. (please contact your energy retailer for the full privacy notice).
- It is a criminal offence under the *Crimes Act 1900* to provide false or misleading information.

Applicant signature:

Date:

### Patient details

|                            |  |
|----------------------------|--|
| <b>Name of patient:</b>    |  |
| <b>Address of patient:</b> |  |

For the purposes of administering this rebate, I consent to the release of the medical information in this application provided by my medical practitioner to my energy retailer.

Patient signature:

Date:

### Consent for person to act on your behalf (optional)

Only complete this section if you would like someone to act on your behalf in relation to this application.

I authorise \_\_\_\_\_, who can be  
contacted by phone on \_\_\_\_\_ or via  
email at \_\_\_\_\_  
to speak to my energy retailer on my behalf about this application.

**I understand that I can withdraw this consent at any time by contacting my retailer**

### Consent to contact (optional)

I consent to my energy retailer contacting me about my experience applying for the rebate.

## Submitting this form to your energy retailer

Before you send this application have you:

- Verified all details you have supplied are correct?
- Filled out all sections of this form?
- Signed and agreed to all the conditions listed in the declaration?
- Confirmed that your medical practitioner has signed and completed all the relevant sections on page 3?

## Medical practitioner details

This section must be completed by the patient's medical practitioner.

|   |  |
|---|--|
| <b>Practitioner name:</b>   |  |
| <b>Provider number:</b>   |  |
| <b>Name of place where patient was reviewed (hospital/clinic/practice):</b>         |  |
| <b>Phone number of place where patient was reviewed (hospital/clinic/practice):</b> |  |

## Medical assessment

To meet the criteria for the NSW Medical Energy Rebate, the patient must have been assessed by a registered medical professional who has been treating them for at least 3 months, where the patient:

- has an inability to self-regulate body temperature
- meets one of the four primary qualifying conditions and one of the three secondary qualifying conditions listed in the table.

## Medical practitioner declaration

I certify that the patient has an inability to self-regulate body temperature. I have been treating the patient for at least 3 months/this patient has been treated by the Royal Flying Doctor Service in remote and regional NSW for at least 3 months, and they meet at least one primary and one secondary qualifying condition as indicated in this table:

| Primary qualifying conditions (select at least one)  | Check box                |
|--|--------------------------|
| Autonomic system dysfunction (medical conditions in which the autonomic system has been damaged, such as severe spinal cord injury, stroke, brain injury and neurodegenerative disorders).   | <input type="checkbox"/> |
| Loss of skin integrity or loss of sweating capacity (e.g. significant burns greater than 20% of the body, severe inflammatory skin conditions and some rare forms of disordered sweating).   | <input type="checkbox"/> |
| Objective reduction of physiological functioning at extremes of environmental temperatures (e.g. advanced multiple sclerosis).   | <input type="checkbox"/> |
| Hypersensitivity to extremes of environmental temperature leading to increased pain or other discomfort or an increased risk of complications (e.g. complex regional pain syndrome and advanced peripheral vascular disease).              | <input type="checkbox"/> |
| Secondary qualifying conditions (select at least one)  | Check box                |
| Severe immobility, such as occurs with quadriplegia or high-level paraplegia, particularly above mid-thoracic level (T7) resulting in problems with self-regulation of body temperature due to loss of sympathetic nervous system control. | <input type="checkbox"/> |
| Demonstrated significant loss of autonomic regulation of sweating, heart rate or blood pressure.   | <input type="checkbox"/> |
| Demonstrated loss of physiological function or significant aggravation of clinical condition at extremes of environmental temperature.   | <input type="checkbox"/> |

I declare that all information provided in this application is, to the best of my knowledge, true and correct.

I consent to the energy retailer contacting me to confirm the accuracy of the personal and health information provided in this form.

Signature of medical practitioner:

Date: