# Hearing Services Program - Tax Invoice and Claim for Payment

| Client Full Name | Voucher Number |
| --- | --- |
|  |  |

## CLAIM DETAILS

| **Qty** | **Item Number & Description of Service** | **Date of Service** (DD/MM/YYYY) | **QP Number.** | **Site ID** | **Cost to**  **Client**  (Add $0 if no cost) | **Item Benefit**  (excluding GST) | **GST Amount** | **Total Benefit**  (GST inclusive) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  | $ | $ | $ | $ |
|  |  |  |  |  | $ | $ | $ | $ |
|  |  |  |  |  | $ | $ | $ | $ |
| **Total service/s item benefit** | | | | | | | | $ |

### Fitting Information (only complete this section if claiming a fitting item above)

| **Ear** | **Device Code** | **Date of Fitting**  (DD/MM/YYYY) | **Tier Category** | **Cost to Client**  (Add $0 if no cost) | **Device Benefit**  (excluding GST) | **GST**  **Amount** | **Total Benefit**  (GST inclusive) |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Left** |  |  |  | $ | $ | $ | $ |
| **Right** |  |  |  | $ | $ | $ | $ |
| **Total device benefit** | | | | | | | $ |

### Total Claim benefit

| Total claim benefit = service item benefit + device benefit (if applicable) | $ |
| --- | --- |
| Total cost of the claim to the client | $ |

### OTHER DETAILS

| Most recent 3FAHL details (1-120dB) | Left (dB) |  | Right(dB) |  |
| --- | --- | --- | --- | --- |

| For Item 960 - Date the client became aidable to one ear (DD/MM/YYYY) |  |
| --- | --- |
| For Item 670 - Please advise the follow-up date (DD/MM/YYYY) |  |
| Remote Control Manufacturer Invoice Cost | $ |

### Certification by Service Provider

| Service Provider Name |  | | | | |
| --- | --- | --- | --- | --- | --- |
| ABN Number |  | | | | |
| Are you income tax exempt? | Yes  No | | Are you GST registered? | | Yes  No |
| I certify that the information provided above is true and correct and the services were provided in accordance with the *Hearing Services Administration Act 1997*, *the Hearing Services Program (Voucher) Instrument 2019*, the Service Provider Contract and Schedule of Service Items and Fees. I understand that providing false information to the Commonwealth is a criminal offence. I certify the above QP number is the number of the practitioner or supervising practitioner who delivered or supervised the service being claimed for. | | | | | |
| **Full Name (Claim submitted by)** | | **Signature** | | **Invoice Issue Date** | |
|  | |  | |  | |