

**Australian Government
Department of Health and Ageing**

Medicare Benefits Schedule Book

**Optometrical Services
Schedule**

Operating from 01 November 2010

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Online ISBN: 978-1-74241-287-0

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Publications Approval Number: 6837

At the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

The latest Medicare Benefits Schedule information is available from *MBS Online* at <http://www.health.gov.au/mbsonline>

INTRODUCTION

This book provides information on the arrangements for the payment of Medicare benefits for optometric services by optometrists who undertake to participate in the benefit arrangements and by optometrists acting on their behalf. These arrangements operate under the *Health Insurance Act 1973* (as amended).

Part 1 of this book contains an outline of the arrangements for optometric benefits and notes for the guidance of participating optometrists, including addresses of the Department and Medicare Australia. Further information on the Medicare Benefits Schedule can be located at the *MBS Online* website.

The Schedule in Part 2 shows the item number, description of service, Schedule fee and Medicare benefit payable in respect of the optometric items.

Part 3 contains a copy of the Common Form of Undertaking which optometrists are required to sign to participate in the arrangements.

CHANGES INCLUDED IN THIS EDITION

The content of this book has been modified to make it more user-friendly.

Schedule fees for optometric items have increased by 1.8% from 1 November 2010.

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PART 1

OUTLINE OF ARRANGEMENTS AND NOTES FOR GUIDANCE

O.1. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for services by participating optometrists. The *Health Insurance Act 1973* contains legislation covering the major elements of the Medicare program.

Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health and Ageing. Medicare Australia is responsible for consideration of applications for the acceptance of optometric Undertakings and for the day to day operation of Medicare and the payment of benefits. Contact details of the Department of Health and Ageing and Medicare Australia (Medicare offices) are located at the end of these Notes.

O.2. PARTICIPATION BY OPTOMETRISTS

Medicare pays benefits for services provided by optometrists who have signed an agreement to participate in arrangements with the Commonwealth Government. This agreement is formally known as the "Common Form of Undertaking - Participating Optometrists" and is often referred to as the 'Participating Agreement' or the 'Undertaking'. A copy of the Undertaking is contained in Part 3 of this book.

An optometrist registered under a law in any State or Territory of Australia, who wishes to become a participating optometrist, is required to sign the Common Form of Undertaking and an employer of optometrists must sign a separate Common Form of Undertaking except where the optometrist and the owner of the business are the same person.

Where the optometric practice is conducted in a corporate form, such as a company or partnership, it is necessary for the corporation to become a "participating optometrist", and an additional Undertaking must be signed by a person who has authority to give the Undertaking on behalf of the organisation.

The Undertaking sets out the obligations to be met under the arrangements. Copies of the Undertaking may be obtained from the Medicare Australia website at www.medicareaustralia.gov.au or by calling 132 150 (charges may apply).

Where an employer of optometrists completes an Undertaking, that Undertaking must identify premises owned by them or in their possession at which he or she provides services of a kind to which the Undertaking relates. The relevant details are to be included in schedules 2 and 3 of the Undertaking. An Undertaking completed by an individual optometrist does not need to identify the premises from which services are to be provided as the Undertaking applies to all premises from which the optometrist will provide services.

When completed, the Undertaking should be returned to:

Manager (Provider Eligibility and Accreditation)
Medicare Australia
PO Box 1001
Tuggeranong ACT 2901.

The Minister may refuse to accept an Undertaking given by an optometrist. In these circumstances the optometrist will be notified in writing of the refusal and is given 30 days to forward a written request to the Minister, to have the matter reviewed.

After acceptance by the Minister, or his delegate, of the completed Undertaking, a letter of acceptance of the Undertaking will be forwarded to the optometrist.

The Manager (Provider Eligibility and Accreditation) must be notified in writing of any changes to the details furnished by an optometrist in schedule 2 and schedule 3 of the Undertaking.

Participating optometrists may at any time terminate Undertakings either wholly or as they relate to particular premises, by notifying:

Manager (Provider Eligibility and Accreditation)
Medicare Australia
PO Box 1001
Tuggeranong ACT 2901.

The date of termination may not be earlier than 30 days after the date on which the notice is served.

O.3. PROVIDER NUMBERS

To ensure that benefits are paid only for services provided by optometrists registered with the Optometry Board of Australia, each optometrist providing services for which a Medicare benefit is payable requires an individual provider number.

Provider numbers will be issued only to registered optometrists. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

Provider numbers are allocated to enable claims for Medicare benefits to be processed. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

Optometrists can obtain a provider number from Medicare Australia. A separate provider number is issued for each location at which an optometrist practises and has current registration. Provider numbers for additional practice locations may also be obtained from Medicare Australia following confirmation of registration. Optometrists cannot use another optometrist's provider number.

Locum Tenens

An optometrist who has signed a Common Form of Undertaking and is to provide services at a practice location as a locum for more than 2 weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

If the locum is to provide services at a practice for less than 2 weeks, the locum can use their own provider number or can obtain an additional provider number for that location.

Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed a Common Form of Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Undertaking.

To ensure benefits are payable when a locum practises in these circumstances, the locum optometrist should:

- Check that they will be providing optometry services on behalf of a participating optometrist i.e. their employer has a current Common Form of Undertaking.
- Complete the Schedule which is available on Medicare Australia's website at www.medicareaustralia.gov.au, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

Locums can direct Medicare payments to a third party, for example the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on bulk bill stationery.

O.4. PATIENT ELIGIBILITY

An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits.

Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas.

Medicare Cards

The **green** Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.

The **blue** Medicare card bearing the words "INTERIM CARD" is for people who have applied for permanent residence.

Visitors from countries with which Australia has a Reciprocal Health Care Agreement (RHCA) receive a card bearing the words "RECIPROCAL HEALTH CARE"

Visitors to Australia and temporary residents

Visitors and temporary residents in Australia are not eligible for Medicare and should therefore have adequate private health insurance.

Reciprocal Health Care Agreements

Australia has Reciprocal Health Care Agreements with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy, Belgium and Malta.

Visitors from these countries are entitled to immediately necessary medical treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits for out of hospital services and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enrol with Medicare Australia to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:

- Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare cards.
- Visitors from Italy and Malta are covered for a period of six months only.

The Agreements do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered. Visitors from New Zealand and the Republic of Ireland are NOT entitled to optometric treatment under a RHCA and all other RHCA visitors are only entitled to immediately necessary treatment.

O.5. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

What services are covered?

The services coming within the scope of the optometric benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to a consultation on ocular or vision problems or related procedures. *The Health Insurance Act 1973*, defines a 'clinically relevant service' as a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

Benefits may only be claimed when:

- (a) a service has been performed and a clinical record of the service has been made;
- (b) a significant consultation or examination procedure has been carried out;
- (c) the service has been performed at premises to which the Undertaking relates;
- (d) the service has involved the personal attendance of both the patient and the optometrist; and
- (e) the service is "clinically relevant" (as defined in the *Health Insurance Act 1973*).

Where Medicare benefits are not payable

Medicare benefits may not be claimed for attendances for:

- (a) delivery, dispensing, adjustment or repairs of visual aids;
- (b) filling of prescriptions written by other practitioners.

Benefits are not payable for optometric services associated with:

- (a) cosmetic surgery
- (b) refractive surgery
- (c) tests for fitness to undertake sporting, leisure or vocational activities

- (d) compulsory examinations or tests to obtain any commercial licence (e.g. flying or driving)
- (e) entrance to schools or other educational facilities
- (f) compulsory examinations for admissions to aged care facilities
- (g) vision screening

Medicare benefits are not payable for services in the following circumstances:

- (a) where the expenses for the service are paid or payable to a recognised (public) hospital;
- (b) where the service is provided by teaching institutions to patients of supervised students;
- (c) where the service is not "clinically relevant" (as described in the *Health Insurance Act 1973*, i.e. a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered).

Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric service where:

- (a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or
- (b) the service was rendered in one or more of the following circumstances –
 - (i) the employer arranges or requests the consultation
 - (ii) the results are provided to the employer by the optometrist
 - (iii) the employer requires that the employee have their eyes examined
 - (iv) the account for the consultation is sent to the employer
 - (v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's workplace.

Services rendered to an optometrist's dependants, employer or practice partner or dependants

A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to his or her employer or practice partner or any dependants of that employer or partner.

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

a *spouse*, in relation to a dependant person means:

- (a) a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and
- (b) a de facto spouse of that person.

a *child*, in relation to a dependant person means:

- (a) a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and
- (b) a person who:
 - (i) has attained the age of 16 years who is in the custody, care and control of the person or the spouse of the person; or
 - (ii) is receiving full time education at a school, college or university; and
 - (iii) is not being paid a disability support pension under the *Social Security Act 1991*; and
 - (iv) is wholly or substantially dependent on the person or on the spouse of the person.

O.6. SCHEDULE FEES AND MEDICARE BENEFITS

Schedule fees and Medicare benefits

Optometrists participating in the scheme agree not to charge more than the Schedule fees for services covered by Medicare, and also, that charges for appliances shall not include any amount related to consultation procedures for which benefits are payable. The only exceptions are for Item 10907 and in relation to domiciliary visits.

The services provided by participating optometrists which attract benefits are set out in the *Health Insurance (General Medical Services Table) Regulations 2009*.

Medicare benefits are payable at 85% of the Schedule fee for services rendered with a maximum gap payment for any one service of \$71.20 (indexed annually) between the Medicare rebate and the Schedule fee.

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2010 is \$388.80 and is indexed annually. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net

Under the extended Medicare safety net (EMSN), once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided on the MBS Online website. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2010, the threshold for singles and families that hold a Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is \$562.90. The threshold for all other singles and families is \$1,126.00.

The thresholds for the EMSN are indexed on 1 January each year.

Individuals are automatically registered with Medicare Australia for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from Medicare Australia offices, or completed online at www.medicareaustralia.gov.au.

Limiting rule for patient claims

Where a fee charged for a service is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the services before they can be regarded as separate attendances.

Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (e.g. 10.30 am and 3.15 pm) in order to assist in the payment of benefits. Times do not need to be specified where a perimetry item is performed in association with a consultation item.

In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Referred comprehensive initial consultations (Item 10905) - Read in conjunction with 09 referrals

For the purposes of Item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

Benefits will be paid at the level of Item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefit under item 10905.

The optometrist claiming the Item 10905 service is obliged to retain the written referral for a period of twenty-four months.

Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation within 24 months of a previous comprehensive consultation (Item 10907)

Where a patient receives a comprehensive initial consultation within 24 months of a previous comprehensive consultation provided by another optometrist, an additional fee may be charged provided that the service is not bulk-billed. The actual additional amount charged is a matter between the optometrist and the patient, but it must not exceed an amount equal to the difference between the Schedule fees for Item 10900 and Item 10907.

In circumstances where an additional fee is charged the optometrist must inform the patient of the benefit payable for Item 10907 at the time of the consultation and that the additional fee will not attract benefits.

Where it is necessary for the optometrist to seek patient information from Medicare Australia in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:-

- (a) the patient is advised of the need to seek the information and the reason the information is required;
- (b) the patient's informed consent to the release of information has been obtained; and
- (c) the patient's records verify the patient's consent to the release of information.

Significant change in visual function requiring comprehensive re-evaluation (Item 10912)

Significant changes in visual function which justify the charging of Item 10912 could include documented changes of:

- vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)
- visual fields or previously undetected field loss
- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss.

New Signs or symptoms/progressive disorder requiring comprehensive re-evaluation (Items 10913 and 10914)

When charging Item 10913 and Item 10914, the optometrist should document the new signs or symptoms or the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (Item 10915)

Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Domiciliary visits (Items 10931 – 10933)

Where patients are unable to travel to an optometrist's practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient's place of residence, and transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

Benefits are payable under items 10931 – 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are:

- the patient's home,
- a residential aged care facility as defined by the *Aged Care Act 1997*, or
- an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

Visits to a hospital are not covered by the new loading, but are covered by the previous arrangements, that is, where a visit to a hospital is provided at the patient's request, an extra fee not exceeding the fee for item 10900 may be charged, in addition to the Schedule fee, providing the service is not bulk-billed. Benefits are not payable in respect of the private charge.

Items 10931 – 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The additional private charge must be calculated so that the **total** charges for the basic service, loading and private charge do not exceed an amount which equals twice the fee for item 10900. The usual requirement that the patient must have requested the domiciliary visit applies.

The choice of appropriate item in the range 10931 - 10933 depends on how many patients are seen at the one location. Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location. Item 10931 can be billed in addition to the consultation item. If the optometrist goes on to see another single patient **at a different location**, that patient can also be billed an item 10931 plus the consultation. However, if two patients are visited at a single location on the same occasion, each of the two patients should be billed item 10932 as well as the consultation item applying to each patient. Similarly, if three patients are visited at a single location on the same occasion, each of the three patients should be billed item 10933 as well as the consultation item applying to each patient.

Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth etc patients. On such occasions, the first three patients should be billed item 10933 as well as the appropriate consultation item, and all subsequent patients may only be billed the appropriate consultation item. Where multiple patients are seen at one location on one occasion, there is no provision for patients to be 'grouped' into twos and threes for billing purposes.

Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service. Domiciliary visit loading items cannot be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941.

Release of prescription

Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by any person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices

The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient. The aftercare period includes all post-operative treatment, whether provided by a medical practitioner or an optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the

patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and the receipt issued to the patient should clearly indicate the fee is non-rebatable.

Computerised Perimetry Services (Items 10940 and 10941)

Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

These items can be billed either in association with comprehensive consultation items 10900, 10905, 10907, 10912, 10913, 10914 or 10915, or independently, but they cannot be billed with items 10916 or 10918. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of 2 perimetry services in any 12 month period may be provided.

Low Vision Assessment (Item 10942)

A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

Item 10942 may be claimed on the same day as either a comprehensive initial consultation or a subsequent consultation, but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

Children's vision assessment (Item 10943)

Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence based optometry practice is observed.

A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

Item 10943 may be claimed on the same day as either a comprehensive consultation or a subsequent consultation, but only where the additional assessment/testing has been carried out on an eligible child. Item 10943 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

O.7. BILLING PROCEDURES

There are three ways benefits may be paid for optometric services:

- (a) the claimant may pay the optometrist's account in full and then claim benefits from a Medicare Australia office by submitting the account and the receipt;
- (b) the claimant may submit the unpaid account to Medicare Australia which will then send a cheque in favour of the optometrist, to the claimant; or
- (c) the optometrist may bill Medicare instead of the patient for the consultation. This is known as bulk billing. If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Note: Additional charges must not be levied in respect of domiciliary visits and consultations covered by Item 10907 if the services are bulk-billed.

Claiming of benefits

The patient, upon receipt of an optometrist's account, has two options open for paying the account and receiving benefits.

Paid accounts

If the account has been paid in full the claimant can obtain a cash benefit (up to certain limits) from a Medicare Australia office. Alternatively they may lodge a claim by post or in the Medicare Australia office drop box, by fax in selected pharmacies and Rural Transaction Centres, or telephone (in rural areas throughout Australia) for a payment by Electronic Funds Transfer (EFT) or cheque.

Practitioners seeking information regarding registration to allow EFT payments and other E-Business transactions, can do so by viewing the Health Professionals section at the Medicare Australia website at www.medicareaustralia.gov.au

Unpaid accounts

Where the patient has not paid the account in full, the unpaid account may be presented to Medicare Australia with a completed Medicare claim form. In this case Medicare Australia will forward to the claimant a benefit cheque made payable to the optometrist.

It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist" cheques involving Medicare benefits must (by law), not be sent direct to optometrists, or to the claimant at an optometrist's address (even if requested by the claimant to do so). "Pay optometrist" cheques are required to be forwarded to the claimant's last known address as recorded with Medicare Australia.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist" cheque the optometrist should indicate on the receipt that a "Medicare cheque for \$..... was involved in the payment of the account". The receipt should also include any money paid by the claimant or patient.

Itemised accounts

When an optometrist bills a patient for a service, the patient should be issued with a correctly itemised account and receipt to enable him/her to claim Medicare benefits. Where both a consultation and computerised perimetry occur, these may be itemised on the same account.

Medicare benefits are only payable in respect of optometric services where it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each service to each patient, the following information:-

- (a) patient's name;
- (b) date on which the service(s) was rendered;
- (c) a description of the service(s) (e.g. "initial consultation, "subsequent consultation" or "contact lens consultation" and/or "computerised perimetry" in those cases where it is performed);
- (d) Medicare Benefits Schedule item number(s);
- (e) the name and practice address or name and provider number of the optometrist who actually rendered the service(s). Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service(s) was given;
- (f) the fee charged for the service(s);
- (g) the time each service began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.

Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number are included on accounts, receipts and assignment of benefit forms.

Details of any charges made other than for services, e.g. a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts

Only one original itemised account per service should be issued, except in circumstances where both a consultation and computerised perimetry occur, in which case these may be itemised on the same original account. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (bulk billed) arrangements

Under the *Health Insurance Act 1973* an Assignment of Benefit (bulk-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If an optometrist bulk-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- the patient's Medicare number must be quoted on all bulk-bill assignment of benefit forms for that patient;
- the assignment of benefit forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the *Health Insurance Act 1973*;
- the optometrist must cause the particulars relating to the professional service to be set out on the assignment of benefit form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;
- where a patient is unable to sign the assignment of benefit form, the signature of the patient's parent, guardian or other responsible person (other than the optometrist, optometrist's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the optometrist. If in the opinion of the optometrist the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Use of Medicare cards in bulk billing

The Medicare card plays an important part in bulk-billed services as it can be used to imprint the patient details (including Medicare number) on the basic assignment of benefit forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare Australia.

The patient details may, of course, be written on the bulk-bill form, but the use of the card to imprint patient details assists optometrists and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare Australia is expedited.

The Medicare card number must be quoted on bulk-bill assignment of benefit forms. If the number is not available, then the bulk bill payment option should not be used as there is a risk that the patient may not be eligible and Medicare benefits not payable.

Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the optometrist may contact Medicare Australia on 132 150 to obtain the number.

It is important for the optometrist to check the eligibility of their patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement.

Assignment of benefit forms

Only the approved assignment of benefit forms available from Medicare Australia can be used to bulk bill patients for optometric services and no other form can be used without its approval.

(a) **Form DB2-OP**

This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy.

(b) **Form DB4**

This is a continuous stationery version of Form DB2 and has been designed for use on most office accounting machines.

The Claim for Assigned Benefits (Form DB1N, DB1H)

Optometrists who accept assigned benefits must claim from Medicare Australia using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to an optometrist other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal optometrist and setting the locum up with a provider number and pay-group link for the principal optometrist's practice is impractical. Optometrists should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

Each claim form must be accompanied by the assignment of benefit forms to which the claim relates.

The DB1N and DB1H are also loose leaf to enable imprinting of the optometrist's details using the special Medicare imprinter. For this purpose, practitioner cards, showing the optometrist's name, practice address and provider number are available from Medicare on request.

Time limits applicable to lodgement of bulk bill claims for benefits

A time limit of two years applies to the lodgement of claims with Medicare Australia under the bulk billed (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare Australia.

Provision exists whereby in certain circumstances (e.g. hardship cases, third party or workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the Medicare Australia website www.medicareaustralia.gov.au or the processing centre to which bulk bill claims are directed.

O.8. LIMITATIONS ON BENEFITS

Single Course of Attention

A reference to a single course of attention means:-

- (a) In the case of Items 10900 to 10918 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

- (b) In relation to Items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses. This includes those after-care visits necessary to ensure the satisfactory performance of the lenses.

Initial consultations

The initial consultation item (Item 10900) is payable once only within 24 months of the previous standard consultation (Item 10900, 10905, 10907, 10912, 10913, 10914 or 10915). However, a benefit is payable under Item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 24 months of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items (see relevant paragraphs at 06).

Where an attendance would have been covered by Item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 but is of 15 minutes duration or less, Item 10916 (Short consultation) applies.

Second or subsequent consultations (Item 10918)

Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by Item 10918.

Contact lens consultations (Items 10921 to 10930)

In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in Items 10921 to 10929. For claims under Items 10921, 10922, 10923, 10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

Medicare benefits are not payable for Item 10929 in circumstances where patients want contact lenses for:

- (a) reasons of appearance (because they do not want to wear spectacles);
- (b) sporting purposes;
- (c) work purposes; or
- (d) psychological reasons (because they cannot cope with spectacles).

All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under Items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. In some cases, where the patient decides not to proceed with contact lenses, no Medicare fee is payable because the patient has not taken delivery of the lenses. In such instances, the patient may be charged a non-rebatable (private) fee for a 'part' service. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses. Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not Items 10921 to 10930).

For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item number should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (e.g. balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

Benefit under Items 10921 to 10929 is payable once only in any period of 36 consecutive months except where circumstances are met under Item 10930 within a 36 month period.

Additional payments for optometrists visiting remote and very remote locations (Visiting Optometrists Scheme)

Special arrangements exist under the provisions of Section 129A of the *Health Insurance Act 1973* to provide financial incentives to optometrists to deliver outreach optometric services to rural and remote locations, which would not otherwise have ready access to primary eye care, with no additional charge to patients. Optometrists are encouraged to provide outreach services to national priority locations, particularly remote and very remote locations, Aboriginal and Torres Strait Islander communities and rural locations with an identified need for optometry services.

Under these arrangements, financial assistance may be provided to approved participating optometrists to cover costs associated with delivering outreach services, including travel, accommodation and meals, facility fees and an absence from practice allowance to compensate for 'loss of business opportunity' due to the time spent travelling to and from an outreach location.

This assistance is provided because the participating nature of the benefit arrangements does not permit optometrists to charge fees higher than Medicare Schedule fees to offset the additional costs involved in visiting rural and remote locations.

A national call for expressions of interest will be undertaken on an annual basis, although applications for priority areas may be considered on a needs basis at any time. Visiting optometrists should also note that Regional Eye Health Coordinators located in several Aboriginal Community Controlled Health Services in each State and Territory may be able to assist in arranging and establishing ongoing visits. Optometrists interested in providing an outreach optometric service should contact the relevant State or Northern Territory Office of the Australian Government Department of Health and Ageing. Contact details of State and Northern Territory offices are located at the end of these Notes.

O.9. REFERRALS

General

Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.

Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefits at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the unREFERRED rate.

Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See relevant paragraph O9 regarding emergency situations.

What is a referral?

For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place:

- (a) the referring optometrist must have turned his or her mind to the patient's need for referral and communicate relevant information about the patient to the specialist ophthalmologist or optometrist to

- whom the patient is referred (but this does not necessarily mean an attendance on the occasion of the referral);
- (b) the instrument of referral must be in writing by way of a letter or note and must be signed and dated by the referring optometrist; and
 - (c) the practitioner to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in the above paragraph are that:

- (a) sub-paragraphs (b) and (c) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see paragraph below on emergency situations); and
- (b) sub-paragraph (c) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid

A referral from an optometrist to an ophthalmologist is valid for 12 months unless the optometrist specifies on the referral that the referral is for a different period (e.g. 3, 6 or 18 months or valid indefinitely).

The referral applies for the period specified in the referral from the date that the ophthalmologist provides the first service to the patient. If there is no period specified in the referral then the referral is valid for 12 months from the date of the first service provided by the ophthalmologist.

Referrals for longer than 12 months should be made only when the patient's clinical condition requires continuing care and management.

An optometrist may write a new referral when a patient presents with a condition unrelated to the condition for which the previous referral to an ophthalmologist was written. In these circumstances Medicare benefits for the consultation with the ophthalmologist would be payable at initial consultation rates.

A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:-

- (a) deems it necessary for the patient's condition to be reviewed; and
- (b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and
- (c) the patient was last seen by the specialist ophthalmologist more than 9 months earlier than the attendance following a new referral.

Self referral

Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Lost, stolen or destroyed referrals

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

Emergency situations

Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the *Health Insurance Regulations 1975*). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment form as an "Emergency referral".

A referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist if attendances subsequent to the emergency attendance are to attract Medicare benefits at the referred rate.

O.10. PROVISION FOR REVIEW OF THE SCHEDULE

Optometric Benefits Consultative Committee (OBCC)

The OBCC is an advisory committee established in 1990 by arrangement between the Minister and Optometrists Association Australia.

The OBCC's functions are:

- (a) to consider the appropriateness of existing Medicare Benefits Schedule items, including the need to combine, delete or create items, and the need to amend item descriptions;
- (b) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;
- (c) to provide a forum for discussion on fees and fee relativities for individual optometric items in the Medicare Benefits Schedule (but not so as to involve a general review of the overall level of optometric fees);
- (d) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the *Health Insurance Act 1973* and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;
- (e) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

The OBCC comprises two representatives from the Department of Health and Ageing, two representatives from Medicare Australia, and three representatives from Optometrists Association Australia.

O.11. PROVISION FOR REVIEW OF PRACTITIONER BEHAVIOUR

Professional Services Review (PSR) Scheme

The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, midwives, nurse practitioners, physiotherapists, podiatrists and osteopaths.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services. It is also an offence under Section 82 for a person or officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Medicare Australia monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, Medicare Australia can request that the Director of PSR review the provision of services by the practitioner. On receiving the request, the Director must decide whether to conduct a review and in which manner the review will be conducted. The Director is authorised to require that documents and information be provided.

Following a review, the Director must:

- (a) decide to take no further action; or
- (b) enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or
- (c) refer the matter to a PSR Committee.

A PSR Committee normally comprises three medically qualified members, two of whom must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide a wider range of clinical expertise.

The Committee is authorised to:

- (a) investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;
- (b) hold hearings and require the person under review to attend and give evidence;
- (c) require the production of documents (including clinical notes).

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be **adequate**, the patient or clinical record needs to:

- clearly identify the name of the patient; and
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and
- each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

To be **contemporaneous**, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

- (i) a reprimand;
- (ii) counselling;
- (iii) repayment of Medicare benefits; and/or
- (iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information on the Professional Services Review is available at www.psr.gov.au or on Medicare compliance is available at www.medicareaustralia.gov.au/provider/business/audits/index.jsp

Penalties

Penalties of up to \$10,000 or imprisonment for up to five years, or both may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee (MPRC) and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to \$1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on an assignment of benefit form without necessary details having been entered on the form before the patient signs or who fails to cause a patient to be given a copy of the completed form.

Medicare Participation Review Committee

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

- (a) has been successfully prosecuted for relevant criminal offences; or
- (b) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

ADDRESSES OF THE DEPARTMENT OF HEALTH AND AGEING

Postal: GPO Box 9848,
in each Capital City

NEW SOUTH WALES 1 Oxford Street DARLINGHURST NSW 2010 Telephone: (02) 9263 3555	VICTORIA 595 Collins Street MELBOURNE VICTORIA 3000 Telephone: (03) 9665 8888	QUEENSLAND 340 Adelaide Street BRISBANE QLD 4000 Telephone: (07) 3360 2555
SOUTH AUSTRALIA Level 13 11-29 Waymouth Street ADELAIDE SA 5000 Telephone: (08) 8237 8111	WESTERN AUSTRALIA Central Park Reception – 14 th Floor 152-158 St George’s Terrace PERTH WA 6000 Telephone: (08) 9346 5111	TASMANIA 1 st Floor 100 Melville Street HOBART TASMANIA 7000 Telephone: (03) 6221 1411
NORTHERN TERRITORY Level 7 Jacana House 39- 41 Woods Street DARWIN NT 0800 Telephone: (08) 8919 3444	AUSTRALIAN CAPITAL TERRITORY Level 1 Canberra House 40 Marcus Clarke Street CANBERRA ACT 2601 Telephone: (02) 6289 1555	

ADDRESSES OF MEDICARE AUSTRALIA

Postal: Medicare Australia
GPO Box 9822
in each Capital City

Provider Enquiries: 132 150 for all States and Territories
Public Enquiries: 132 011 for all States and Territories

NEW SOUTH WALES Medicare Australia Paramatta Office 130 George Street PARRAMATTA NSW 2150	VICTORIA Medicare Australia Melbourne Office Level 10 595 Collins Street MELBOURNE VIC 3000	QUEENSLAND Medicare Australia Brisbane Office 143 Turbot Street BRISBANE QLD 4000
SOUTH AUSTRALIA Medicare Australia Adelaide Office 209 Greenhill Road EASTWOOD SA 5063	WESTERN AUSTRALIA Medicare Australia Perth Office Level 4 130 Stirling Street PERTH WA 6003	TASMANIA Medicare Australia Hobart Office 199 Collins Street HOBART TAS 7000
NORTHERN TERRITORY As per South Australia	AUSTRALIAN CAPITAL TERRITORY Medicare Australia National Office 134 Reed Street North GREENWAY ACT 2901	

PART 2

SCHEDULE OF SERVICES

SERVICES	SERVICES
	GROUP A10 - OPTOMETRICAL SERVICES
	COMPREHENSIVE INITIAL CONSULTATION
10900	<p>Professional attendance of more than 15 minutes duration, being the first in a course of attention - not payable within 24 months of an attendance to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 applies (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$68.35 85% = \$58.10</p>
	REFERRED COMPREHENSIVE INITIAL CONSULTATION
10905	<p>Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$68.35 85% = \$58.10</p>
	COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER WITHIN 24 MONTHS OF A PREVIOUS COMPREHENSIVE CONSULTATION
10907	<p>Professional attendance of more than 15 minutes duration being the first in a course of attention where the patient has attended another optometrist within the previous 24 months for an attendance to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 applies (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$34.20 85% = \$29.10</p>
	OTHER COMPREHENSIVE CONSULTATIONS
10912	<p>Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has suffered a significant change of visual function requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 at the same practice applies (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$68.35 85% = \$58.10</p>
10913	<p>Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 at the same practice applies (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$68.35 85% = \$58.10</p>
10914	<p>Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 applies (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$68.35 85% = \$58.10</p>
10915	<p>Professional attendance of more than 15 minutes duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus requiring comprehensive reassessment. (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$68.35 85% = \$58.10</p>
	BRIEF INITIAL CONSULTATION
10916	<p>Professional attendance, being the first in a course of attention, of not more than 15 minutes duration, not being a service associated with a service to which item 10931, 10932, 10933, 10940, 10941, 10942 or 10943 applies (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$34.20 85% = \$29.10</p>
	SUBSEQUENT CONSULTATION
10918	<p>Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses, not being a service associated with a service to which item 10940 or 10941 applies (See para 06 of explanatory notes to this Category)</p> <p>Fee: \$34.20 85% = \$29.10</p>

SERVICES		SERVICES
<p>CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS - BULK ITEMS FOR ALL SUBSEQUENT CONSULTATIONS</p> <p><i>Note: Benefits may not be claimed under Item 10929 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons – see relevant O8 paragraphs of explanatory notes to this category.</i></p> <p>All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies - payable only once in a period of 36 months</p>		
10921	- patients with <u>myopia of 5.0 dioptres or greater</u> (spherical equivalent) in 1 eye	Fee: \$169.45 85% = \$144.05
10922	- patients with <u>manifest hyperopia of 5.0 dioptres or greater</u> (spherical equivalent) in 1 eye	Fee: \$169.45 85% = \$144.05
10923	- patients with <u>astigmatism of 3.0 dioptres or greater</u> in 1 eye	Fee: \$169.45 85% = \$144.05
10924	- patients with <u>irregular astigmatism</u> in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	Fee: \$213.85 85% = \$181.80
10925	- patients with <u>anisometropia of 3.0 dioptres or greater</u> (difference between spherical equivalents)	Fee: \$169.45 85% = \$144.05
10926	- patients with corrected <u>visual acuity of 0.7 logMAR (6/30) or worse</u> in both eyes, being patients for whom a contact lens is prescribed as part of a <u>telescopic system</u>	Fee: \$169.45 85% = \$144.05
10927	- patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: (i) <u>pathological mydriasis; or</u> (ii) <u>aniridia; or</u> (iii) <u>coloboma of the iris; or</u> (iv) <u>pupillary malformation or distortion; or</u> (v) <u>significant ocular deformity or corneal opacity</u> whether congenital, traumatic or surgical in origin	Fee: \$213.85 85% = \$181.80
10928	- patients who, by reason of <u>physical deformity</u> , are unable to wear spectacles	Fee: \$169.45 85% = \$144.05
10929	- patients who have a <u>medical or optical condition</u> (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, where the <u>condition is specified</u> on the patient's account	Fee: \$213.85 85% = \$181.80
10930	<p>All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a <u>change in contact lens material or basic lens parameters</u>, other than a simple power change, because of a <u>structural or functional change in the eye or an allergic response</u> within 36 months of the fitting of a contact lens covered by item 10921 to 10929</p>	

SERVICES	SERVICES
10931	<p>DOMICILIARY VISITS</p> <p>An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10932, 10933, 10940 or 10941) applies (the applicable item) if the service is:</p> <ul style="list-style-type: none"> a) rendered at a place other than consulting rooms, being at: <ul style="list-style-type: none"> (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on one patient at a single location on one occasion, and c) either: <ul style="list-style-type: none"> (i) bulk-billed in respect of the fees for both: <ul style="list-style-type: none"> - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: <ul style="list-style-type: none"> - this item; and - the applicable item <p><i>(See para 06 of explanatory notes to this Category)</i></p> <p>Fee: \$23.80 85% = \$20.25</p>
10932	<p>An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is:</p> <ul style="list-style-type: none"> a) rendered at a place other than consulting rooms, being at: <ul style="list-style-type: none"> (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on two patients at the same location on one occasion, and c) either: <ul style="list-style-type: none"> (i) bulk-billed in respect of the fees for both: <ul style="list-style-type: none"> - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: <ul style="list-style-type: none"> - this item; and - the applicable item <p><i>(See para 06 of explanatory notes to this Category)</i></p> <p>Fee: \$11.85 85% = \$10.10</p>
10933	<p>An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10932, 10940 or 10941) applies (the applicable item) if the service is:</p> <ul style="list-style-type: none"> a) rendered at a place other than consulting rooms, being at: <ul style="list-style-type: none"> (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on three patients at the same location on one occasion, and c) either: <ul style="list-style-type: none"> (i) bulk-billed in respect of the fees for both: <ul style="list-style-type: none"> - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: <ul style="list-style-type: none"> - this item; and - the applicable item <p><i>(See para 06 of explanatory notes to this Category)</i></p> <p>Fee: \$7.90 85% = \$6.75</p>
10940	<p>COMPUTERISED PERIMETRY</p> <p>Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - to a maximum of 2 examinations (including examinations to which item 10941 applies) in any 12 month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies</p> <p><i>(See para 06 of explanatory notes to this Category)</i></p> <p>Fee: \$65.20 85% = \$55.45</p>

PART 3

COMMON FORM OF UNDERTAKING

Common Form of Undertaking

Participating Optometrists

Sections 23A and 23B Health Insurance Act 1973

For the purposes of section 23A of the *Health Insurance Act 1973* (the Act)

I, _____ (full name in BLOCK letters)

of _____ (address for correspondence)

being

an optometrist registered to practice optometry in a State or Territory of Australia; or

a person/s who employs optometrists to provide services in the course of the practice of their profession; or

both of the above

(Choose one of the above options by marking a cross in the appropriate box)

who wishes to become a Participating Optometrist, hereby give the following undertaking to the Minister for Health and Ageing for and on behalf of the Commonwealth of Australia.

(Where this undertaking is made on behalf of a company or partnership which employs optometrists, it should be signed by a person who has the authority to make such undertakings on behalf of the company or, in the case of a partnership, by one of the partners on behalf of the partnership)

INTRODUCTION

1 The Minister has, pursuant to subsection 23A(1) of the Act, after consultation with Optometrists Association Australia, drawn up a common form of Undertaking to be given by an optometrist who wishes to become a Participating Optometrist. Definitions, interpretation and other formalities relating to this Undertaking are at Schedule 1.

2 *Date on which an Undertaking comes into force*

2.1 An Undertaking comes into force on the day on which it is accepted by the Minister.

3 *Services to which this Undertaking relates*

3.1 This Undertaking relates to any clinically relevant service ordinarily rendered by an optometrist in relation to consultation on ocular or vision problems, but does not include:

- (a) an attendance for the sole purpose of delivering a prescribed visual aid or appliance or adjusting or repairing such an aid or appliance;
- (b) an attendance for the purpose of filling a prescription written by another practitioner;
- (c) an attendance on behalf of teaching institutions on patients of supervised students of optometry;
- (d) an attendance by an optometrist on:
 - (i) any dependant of the Optometrist;
 - (ii) a practice partner of the Optometrist or any dependants of that partner;
 - (iii) an employer of the Optometrist or any dependants of that employer;
- (e) anything done or service provided at any premises other than those specified in this Undertaking.

4 *Premises to which this Undertaking relates*

4.1 Where this Undertaking is signed by a person/s who employs optometrists to provide services in the course of the practice of optometry, the premises to which this Undertaking relates are those:

- (a) specified in Schedule 2; and
- (b) any other premises at which a domiciliary visit is made.

5 *Termination of Undertaking*

5.1 This Undertaking shall continue to be in force until it is:

- (i) terminated by the Optometrist under subsection 23B(6) of the Act; or
- (ii) revoked by the Minister following a determination of fraudulent or inappropriate practice.

5.2 A Participating Optometrist may, at any time, terminate an Undertaking, either wholly or in so far as it covers particular premises, by serving, as prescribed, a notice of termination to the Managing Director, Medicare Australia, specifying a date of termination not earlier than 30 days after the day on which the notice is served.

UNDERTAKING

6 *Fees*

- 6.1 I undertake to charge fees which do not exceed the Medicare Schedule fee for any service to which this Undertaking and a Medicare item apply, except in the case of:
- (i) a domiciliary visit where an additional fee per patient may apply, not exceeding the Medicare Schedule fee for Item 10900 less the domiciliary loading, so that the maximum total fee that may be charged is twice the fee for Item 10900 where a comprehensive consultation is provided and 1.5 times the fee for Item 10900 where a subsequent consultation is provided; and
 - (ii) a patient being billed an Item 10907 attendance where an additional fee not exceeding an amount equal to the difference between the Medicare Schedule fee for Item 10900 and Item 10907 may apply. The appropriate fee for patient billing purposes in such cases should not exceed the Medicare Schedule fee for Item 10900.
- 6.2 I undertake that when I charge an additional fee as specified in subclause 6.1(ii), I will inform the patient of the Medicare benefit payable for Item 10907, at the time of the consultation, and that the additional fee will not attract benefits.
- 6.3 I undertake that I will obtain the patient's informed consent to the release of information to me if it is necessary for me to seek patient information from Medicare Australia in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims.
- 6.4 I undertake that I will not include an amount that relates to a service to which this Undertaking and a Medicare item apply in any charge made for appliances.
- 6.5 I undertake that I will not include a fee for a visit made or a service provided which is not a service to which this Undertaking applies in any charge made in respect of a Medicare item.

7 *Billing procedures*

- 7.1 I undertake to issue a receipt, or an account and a receipt, as the case may require, for all attendances made by myself, or on my behalf, to which a Medicare item applies, except where an assignment of benefit is made in accordance with section 20A of the Act.
- 7.2 I undertake that any receipt or account issued as provided in subclause 7.1 will contain the details of:
- (a) any additional fee for a domiciliary visit where applicable (subclause 6.1(i));
 - (b) any additional fee in respect of Item 10907 (subclause 6.1(ii)); and
 - (c) the particulars prescribed in regulations made from time to time pursuant to subsection 19(6) of the Act.
- 7.3 I undertake that I will ensure that no fee is charged, nor an assignment of benefit made under section 20A of the Act for an attendance to which one of Items 10921-10930 inclusive relates before the date on which the patient takes delivery of the contact lenses.
- 7.4 I undertake that I will ensure that in respect of each service:
- (a) only one original of the receipt or account is issued; and
 - (b) where a duplicate receipt or account is issued it is clearly marked "duplicate".

- 7.5 I undertake that I will take all reasonable steps to ensure that all items are billed in accordance with this Undertaking and the appropriate Medicare items.
- 7.6 I undertake to accept the relevant Medicare benefit as full payment for the consultation where an assignment of benefit is made in accordance with section 20A of the Act. I accept that additional charges for that service (irrespective of the purpose or title of the charge) *cannot* be raised against the patient, including the special circumstances relating to domiciliary visits and consultations covered under Item 10907.

8 Referral

- 8.1 I undertake that I will ensure that a patient is referred to a medical practitioner when it becomes apparent to the Attending Optometrist that the condition of the patient is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.
- 8.2 I undertake that I will refer patients to other optometrists solely on the basis of the clinical needs of the patient.

9 Prescriptions

- 9.1 I undertake that I will ensure that patients are informed that they are entitled to a copy of their spectacle prescription, and that they are free to have the prescribed spectacles dispensed by any person of their choice.
- 9.2 I undertake that I will ensure that where a contact lens prescription is prepared for the patient, the contact lens prescription is available to the patient at the completion of the prescription and fitting process.

10 Recalls

- 10.1 I undertake that any notice sent to a patient by me or on my behalf suggesting re-examination will be sent solely on the basis of the clinical needs of the patient.

11 Advertising

- 11.1 I undertake that I will not advertise or allow any person to advertise on my behalf in a manner that would lead to claims for Medicare benefits for services that are not Clinically Relevant Services as defined in the Act.

12 Notification of changes in practice details

- 12.1 I/we, as an employer of optometrists, undertake that in the event of a change in, or addition to, the details of the practice, as set out in Schedule 2, I/we will provide Medicare Australia with details of the change or addition within 28 days of the change or addition.

13 Supply of Information

- 13.1 I undertake to furnish to the Minister such information relating to the rendering of services by, or on behalf of, the Optometrist as is from time to time reasonably requested by the Minister.

[Signature]

[Date]

[Witnesses]

Schedule 1

Definitions, Interpretation and Other Formalities

1 *Definitions*

In this Undertaking:

- (a) **"Act"** means the *Health Insurance Act 1973*;
- (b) **"Attending Optometrist"** means an optometrist as defined in subsection 3(1) of the Act, who renders the service;
- (c) **"Clinically Relevant Service"** means a service rendered by an optometrist that is generally accepted in the optometrical profession as being necessary for the appropriate treatment of the patient to whom it is rendered;
- (d) **"Commonwealth"** means the Commonwealth of Australia;
- (e) **"Department of Health and Ageing"** means the Australian Government Department of Health and Ageing or, where the subject matter of the Undertaking is transferred to another Australian Government Department or Agency, that other Department or Agency;
- (f) **"Domiciliary Visit"** means a professional attendance to which an item in the General Medical Services Table relates, given at the request of patients, either at their place of residence or at a nursing home, hospital or other temporary place of residence of the patient;
- (g) **General Medical Services Table** means a table of medical services prescribed under section 4 of the Act in the Regulations, as varied from time to time;
- (h) **Medicare benefit** means a benefit payable by the Commonwealth in relation to a professional service to which a Medicare item applies;
- (i) **Medicare item** means an item specified in the General Medical Services Table;
- (j) **Medicare Schedule fee** means a fee specified for a Medicare item;
- (k) **"Minister"** means the Minister responsible for administering the Department of Health and Ageing and includes:
 - (i) any other Minister of the Commonwealth of Australia who is for the time being acting for that Minister;
 - (ii) a person to whom the relevant powers or functions of the Minister are for the time being delegated;
- (l) **"Optometrist"** for the purposes of sections 23A and 23B of the Act, includes a person who employs optometrists to provide services in the course of the practice of their profession;
- (m) **"Participating Optometrist"** means an optometrist or other person in respect of whom there is in force an Undertaking given by that person and accepted by the Minister under section 23B of the Act;
- (n) **"Person"** includes a body politic or corporation as well as an individual;
- (o) **"Service"** means a professional service specified in a Medicare item that relates to an attendance by a Participating Optometrist;
- (p) **"Undertaking"** means this Common Form of Undertaking and any Schedules hereto as each may be amended from time to time.

2 *Interpretation*

In this Undertaking, unless contrary intention appears:

- (a) a reference to a clause refers to the relevant clause to this Undertaking;
- (b) a reference to a Schedule is to the relevant Schedule of this Undertaking and if a Schedule is at any time varied extends to the Schedule as so varied;
- (c) words in the singular include the plural and words in the plural include the singular;
- (d) the terms AI≡ and Ame≡ refer to the company or the body corporate where a company or a body corporate is making an undertaking; and
- (e) words and expressions used in the Undertaking have the meaning given to them in Schedule 1 of the Undertaking and the Act.

3 *Operation of Undertaking*

If the Act or the Regulations are amended this Undertaking will be read as amended to comply with the then current form of the Act or Regulations.

Any amendments to the Undertaking will be notified in writing to the Optometrist within 28 days of their coming into force or on such earlier day specified by the Minister not being a day earlier than the day on which the amendment was received by Medicare Australia.

4 *Variation of Undertaking*

This Undertaking is subject to variation as provided in subsections 23A(3) and 23B(5) of the Act.

5 *Notices*

Any notice or other communication to the Optometrist under, or for the purpose of, this Undertaking by the Minister shall be deemed to have been duly given or made if it is in writing signed by or on behalf of the Minister or in the case of a delegate signed by that delegate and is sent by prepaid post addressed to the Optometrist at the address shown in Schedule 3 for the forwarding of notices or at such other address as is notified in writing, from time to time, by the Optometrist to the Minister or his delegate for that purpose.

Any notice, or other communication to the Minister under, or for the purpose of, this Undertaking by the Optometrist shall be deemed to have been duly given or made if it is in writing, signed by or on behalf of the Optometrist, addressed to the Minister and is served personally or by being sent by prepaid post, addressed to the Manager, Medicare Australia in the State in which the premises to which the Undertaking applies are situated. If the premises are situated in the Australian Capital Territory or the Northern Territory, the notice is to be addressed to the General Manager, Medicare Australia, PO Box 1001, Tuggeranong ACT 2901.

A notice, or other communication sent by post shall be deemed to have been received by the Optometrist or the Minister as the case may be, when it would have been delivered in the ordinary course of mail delivery.

Schedule 2

Premises to which this Undertaking relates

The premises specified for the purposes of this Undertaking are located at:

[Address 1]

[Address 2]

[Address 3]

[Etc]

Schedule 3

Address for correspondence

Notices or other communications to the Optometrist relating to this Undertaking should be directed to:

[Name & Address]