Australian Government
Department of Health

National Epidermolysis Bullosa Dressing Scheme (NEBDS)

Application Form

About NEBDS: NEBDS aims to support better health outcomes for people with Epidermolysis Bullosa (EB) by improving access to subsidised dressings, bandages and ancillary products used in the management of their chronic conditions. The Scheme is funded by the Australian Government.

Eligibility to NEBDS: Australians (citizens and permanent residents) who have Simplex/Junctional/ Dystrophic/Kindler EB or their subtypes, are Medicare eligible and are referred by a Specialist Health Care Professional (HCP) approved under the NEBDS, are able to access products listed on the NEBDS Schedule under subsidy.

Assistance and Information: For assistance or information (e.g. list of approved Specialist HCPs, NEBDS Schedule and Eligibility Guidelines), please contact the NEBDS Administrator, on 1300 290 400 or email: eb@iagroup.org.au

Lodgment of Application:

- **For new applicants,** complete all sections (Section 1, 2 and 3) of this form.
- **For current NEBDS recipients,** only complete Section 3 of this form.

Once completed, the form and any supporting documents (e.g. copy of Medicare card, Health Care card, biopsy/diagnosis/test reports) should be sent to the NEBDS Administrator via email, fax or mail:

Email: eb@iagroup.org.au **Fax:** 1300 793 132

Mail: NEBDS Administrator, c/o - Independence Australia, Building 1, 9 Ashley Street, West Footscray VIC 3012

- **Please complete this form using a black or blue pen.**
- **For current recipients under NEBDS, complete Section 3 only.**

SECTION 1 - Applicant's Particulars

1 Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

Given names

2 Date of birth (dd/mm/yyyy) / /

3 Sex: Male ☐ Female ☐ Intersex ☐
Indeterminate or Unspecified ☐

4 Medicare number
☐☐☐☐ / ☐☐☐☐☐ / ☐ / ☐
Valid to (mm/yyyy) /

5 Are you of Aboriginal or Torres Strait Islander Australian descent (Question 5 is optional)?
Yes ☐ No ☐

6 Your contact details

Phone number ( )

Alternative phone number ( )

Email

7 Your address

Permanent address

Suburb

State Postcode

Postal/delivery address

Suburb

State Postcode

8 Do you have a valid concession card from the following list:

- ☐ Health Care Card
- ☐ Pensioner Concession Card
- ☐ Commonwealth Seniors Health Card
- ☐ DVA White, Orange, or Gold Card

Authorised Representative

9 If you have or wish to nominate an Authorised Representative to act on and/or communicate on your behalf, please provide the details of the person:

Name

Phone number ( )

Alternative phone number ( )

Email

Relationship to the Applicant

Orders and Delivery

10 Will you or your Authorised Representative be able to confirm your orders?

Yes ☐ No ☐

11 Will someone be available at your delivery address, during business hours, to receive the delivery of your orders?

Yes ☐ No ☐

Privacy and Your Personal Information

- Personal information is protected by law, including the *Privacy Act 1988*, and is being collected on this form by the NEBDS Administrator on behalf of the Australian Government Department of Health (Department) to:
  (a) determine the applicant's eligibility to receive subsidised products and other support under the NEBDS; and
  (b) provide products and support available under the NEBDS to an approved applicant.
- If the information requested in this form is not provided, the Department may not have the necessary details to make a decision on the applicant's eligibility for NEBDS and/or provide the products and support available under NEBDS.
- You can get more information about the way in which the NEBDS Administrator and the Department will manage your personal information, including the respective privacy policies at: https://www.ebdressings.com.au/privacy; and http://www.health.gov.au/internet/main/publishing.nsf/Content/eb-dressing-1#patients

Applicant Consent and Declaration

- I am the applicant or the Authorised Representative of the applicant applying for access to the NEBDS;
- I consent to the Department collecting and disclosing, as necessary, personal information provided in this form for the purpose of determining the applicant's eligibility for NEBDS and, if approved, providing products and support available under NEBDS; and
- If this application is approved, I agree to adhere to the terms and conditions of NEBDS as outlined in the *National Epidermolysis Bullosa Dressing Scheme Eligibility Guidelines*.

Signature Applicant or Authorised Representative

Date / /

SECTION 2 - Specialist HCP Referral

This section of the form must be completed by a Specialist HCP approved under the NEBDS.

12 Applicant Name

13 Date of birth / /

14 Diagnosis

The applicant has a diagnosed condition of:

☐ Dystrophic EB ☐ EB Simplex

☐ Junctional EB ☐ Kindler Syndrome

EB Subtype _____

15 Method of Diagnosis

- ☐ Skin biopsy (attach biopsy report)
- ☐ Genetic test (attach test report)
- ☐ Clinical diagnosis (provide brief explanation)

_____

_____

16 Recommended Clinical Follow Up Intervals

☐ 3 ☐ 6 ☐ 9 ☐ 12 months

17 Health Professional Details

☐ Dr ☐ Assoc. Prof ☐ Professor

Name

Provider number

Signature

Date / /

SECTION 3 - Dressing Requirements

This section of the form must be completed by a Specialist or Treating HCP approved under the NEBDS.

Please refer to the NEBDS Schedule for list of approved dressings, bandages and ancillary products subsidised under the NEBDS. Only products listed on the Schedule can be supplied under the NEBDS.

Applicant / Recipient Details

Name | Date of birth / /

☐ New applicant (initial authorisation) | Medicare number

☐ Current recipient (authorisation to change/update requirements)

Reason for modifying dressing requirements _____

Monthly Dressing Requirements

Product Code	Brand / Manufacturer	Product Description	Size	Quantity	State piece, box or carton

Attach additional page if required.

Health Professional Declaration

I have assessed the applicant's/recipient's full list of monthly dressing requirements and listed them above. I have also advised the applicant/recipient on appropriate usage of dressings, bandages and ancillary products to manage their condition of EB.

Name | Provider/Registration number

Signature

Date / /

Paste physician's label here (if applicable)