



APPLICATION FOR SECOND-TIER DEFAULT BENEFITS ELIGIBILITY

Second-tier default benefits eligibility provides access to higher benefits than would otherwise be payable, in some cases, where a private hospital does not have a negotiated agreement with a patient's insurer. Applying for second-tier default benefits eligibility is optional for private hospitals and requires hospitals to meet the assessment criteria in Schedule 5 of the *Private Health Insurance (Benefit Requirements) Rules 2011*.

Schedules 1, 2 and 3 of the *Private Health Insurance (Benefit Requirements) Rules 2011* provide that private health insurers must pay minimum accommodation benefits for most episodes of hospital treatment. These minimum benefits are sometimes referred to as the basic default benefit.

Schedule 5 of the *Private Health Insurance (Benefit Requirements) Rules 2011* requires private health insurers to pay second-tier default benefits for most episodes of hospital treatment where the insurer does not have a negotiated agreement with a private hospital that is eligible for second-tier default benefits. Second-tier default benefits are calculated as not less than 85 per cent of the average charge for the equivalent episode of hospital treatment under that insurers negotiated agreements with comparable private hospitals in the state in which the second-tier eligible hospital is located.

Completing this form will provide the Minister for Health or the Minister's delegate with the necessary details for determining whether to place a hospital in the second-tier eligible hospitals class, pursuant to section 121-8A of the *Private Health Insurance Act 2007* and Part 2A of the *Private Health Insurance (Health Insurance Business) Rules 2018*.

Before completing this form, hospitals should seek their own advice about the value of being eligible for second-tier default benefits and the hospital's ability to meet the assessment criteria.

[The second-tier default benefit guidelines](#) provide information about how to apply for second-tier default benefits eligibility, including what evidence is required in support of an application.

Complete this form by entering the information in the fields provided. Save the form as a PDF document. The completed form should be forwarded to phi.hospitals@health.gov.au together with all required attachments.

APPLICATION FEE

- The current application fee is \$895. GST is not applicable to the fee.
- Upon receiving a complete application, the Department will issue an invoice for the application fee, usually within three business days.
- The application fee must be paid within seven days of receiving the invoice and may be paid by electronic funds transfer, credit card, cheque or BPAY.
- The Department may not commence any part of application assessment until the application fee has been paid in full.

The fee covers the cost of assessing an application for one hospital. Hospital groups seeking eligibility for multiple hospitals must pay one application fee per hospital. There is no provision to waive the application fee. Upon receipt of payment, the application becomes valid and application assessment can then commence.

HOSPITAL DETAILS
<input type="checkbox"/> Existing Hospital and re-applying (currently hold second-tier eligibility) <input type="checkbox"/> Existing Hospital (currently do not hold second-tier eligibility) <input type="checkbox"/> New Hospital - first application
Hospital name (should match licence/registration): Enter the name of the hospital here.
Legal entity (should match licence/registration): Enter the name of the legal entity
ABN: Enter the entity's ABN here
Commonwealth Provider Number: Enter Commonwealth Provider Number (if known).
Hospital Physical Address
Street: Enter the physical street address of the hospital here.
Suburb / Town: Enter the suburb or town in which the hospital is located.
State/Territory: Select the state or territory in which the hospital is located.
Postcode: Enter the postcode of the hospital here.
Address for Correspondence
Street / PO Box: Enter the street address or PO box for correspondence here.
Suburb / Town: Enter the suburb or town for correspondence here.
State/Territory: Select the state or territory for correspondence here.
Postcode: Enter the postcode for correspondence here.
Contact details for this Application
Contact for this application: Enter the name of the contact person for this application here.
Position of contact: Enter the position of the contact person for this application here.
Phone number of contact: Enter the phone number for the contact person here.
Email address for contact: Enter the email address for the contact person here.
Administration email address for hospital: Enter the hospital's administrative email address only.

ASSESSMENT CRITERIA
a) Be a private hospital
<input type="checkbox"/> This hospital is declared as a private hospital under section 121-5(6) of the <i>Private Health Insurance Act 2007</i> . OR <input type="checkbox"/> This hospital is awaiting the outcome of an application for declaration as a private hospital under section 121-5(6) of the <i>Private Health Insurance Act 2007</i> . Date declaration submitted: Select the date on which the application for declaration was submitted.
b) Be accredited
<input type="checkbox"/> This hospital has a current accreditation or interim accreditation from an authorised accrediting agency. <input type="checkbox"/> Second edition (accreditation process commenced after 1 January 2019 with Second edition noted on certificate); or <input type="checkbox"/> First edition (accreditation process commenced prior to 1 January 2019); or <input type="checkbox"/> Maintained accreditation status due to the COVID-19 Pandemic If hospital has not undergone an accreditation assessment at the time the application for second-tier eligibility is due, it must supply the following information to support its accreditation status: <ul style="list-style-type: none"> • Most recent accreditation certificate to the National Safety and Quality Health Service (NSQHS) Standards • If that accreditation is first edition, the hospital must also provide Informed Financial Consent (IFC) and procedures - see d) for details.
c) Not bill patients directly for the minimum benefit payable by the patient's insurer
<input type="checkbox"/> This hospital will claim second-tier default benefits directly from the patient's health insurer and only bill the patient for any charges over and above the benefit, including any excess payable under the patient's health insurance policy.
d) Make provision for informed financial consent (only required if accreditation is first edition)
<input type="checkbox"/> The hospital is accredited against the second edition of the National Safety and Quality Health Service Standards (NSQHS). Go to part (e) <input type="checkbox"/> The hospital is accredited against the first edition, please provide: <ul style="list-style-type: none"> <input type="checkbox"/> a document outlining internal procedures the hospital has in place to provide informed financial consent to patients or nominees. (see page 5 of Guidelines); and

ASSESSMENT CRITERIA

- ☐ a de-identified sample informed financial consent form, for treatment at the hospital as per the criterion in the Private Health Insurance Second-Tier Default Benefit Guidelines.

Note: an example of an informed financial consent form can be found at the Australian Commission on Safety and Quality in Health Care in [Advisory 18/10 Informed financial consent](#)

e) Submit Hospital Casemix Protocol Data to health insurers electronically with every claim for second-tier default benefits

- ☐ Hospital Casemix Protocol (HCP) data will be submitted to health insurers electronically with every claim for second-tier default benefits.

If the hospital has not provided HCP data with any claims for second-tier default benefits in the past 12 months, please outline the reason.

If applicable, enter the reason HCP data was not provided here. (e.g. new hospital)

SECOND-TIER HOSPITAL CATEGORY

Hospital Bed Numbers: Enter the number of beds the hospital is licensed to operate.

Which one of the following categories best describes the hospital?

- ☐ (a) Private hospitals that provide psychiatric care, including treatment of addictions, for at least 50% of the episodes of hospital treatment, and do not fall into category (g).
- ☐ (b) Private hospitals that provide rehabilitation care for at least 50% of the episodes of hospital treatment, and do not fall into categories (a) or (g).
- ☐ (c) Private hospitals that do not fall into categories (a), (b) or (g), with up to and including 50 licensed beds.
- ☐ (d) Private hospitals that do not fall into categories (a), (b) or (g), with more than 50 licensed beds and up to and including 100 licensed beds.
- ☐ (e) Private hospitals that do not fall into categories (a), (b) or (g), with more than 100 licensed beds, without an accident and emergency unit or a specialised cardiac care unit or an intensive care unit.
- ☐ (f) Private hospitals that do not fall into categories (a), (b) or (g), with more than 100 licensed beds, with either (or any combination of) an accident and emergency unit or a specialised cardiac care unit or an intensive care unit.
- ☐ (g) Private hospitals that provide episodes of hospital treatment only for periods of not more than 24 hours.

ATTACHMENTS

The following mandatory documents have been attached to this application:

- ☐ Current hospital state licence noting individual hospital name; or
 - ☐ Alternative evidence of the number of beds and bed equivalents the hospital operates if the state or territory does not issue a licence that shows bed numbers.
- ☐ Current hospital accreditation certificate or interim certificate noting individual hospital name (if accredited against the second edition of the NSQHS, second edition must be noted on the certificate).
- ☐ Sample informed financial consent (IFC) document and hospital internal IFC procedures if accredited against the first edition of the NSQHS.

DECLARATION

I declare that the information provided in this form is accurate and complete and that I have the authority to lodge this application on behalf of the hospital.

Name and title: Enter full name

Date: Select date document being signed

Position: Enter your position

Email the completed form to phi.hospitals@health.gov.au together with all required attachments.