GENERAL PRACTICE RURAL INCENTIVES PROGRAM (GPRIP)
HEALTH CARE HOMES REVIEW FORM

This form is for medical practitioners participating in the stage one trial of Health Care Homes in a Modified Monash (MM) 3 to 7 location who bill the Medicare Benefits Schedule (MBS) for all other eligible services. If you are not billing the MBS for all other eligible services you may need to apply through the Flexible Payment System (FPS) by contacting the Rural Workforce Agency in the state or Northern Territory in which you have provided the majority of services.
Visit the GPRIP – Stage One Trial of Health Care Homes webpage for more information.

To check your practice MM location, visit the DoctorConnect website at http://www.doctorconnect.gov.au/.

This form prompts a review of your activity to ensure your GPRIP eligibility and payments are reflective of the services you have provided to Health Care Homes patients. This form must be completed and submitted to gprip@health.gov.au within:

- six months of the date of any Payment Advice letter from the Department of Human Services (Human Services) for the relevant period; **or**
- six months of the last day of the fourth quarter of unpaid eligible GPRIP activity (if you have not received a Central Payment System [CPS] payment for the period).

No forms submitted after six months will be processed.

FILLING IN THIS FORM: In the boxes on the following pages, enter your details and the average total hours per week spent providing eligible GPRIP services at MM 3 to 7 locations, within each quarter (include time spent providing services to all patients, including those participating in Health Care Homes). Please place activity in blocks using 'Date Commenced' and 'Date Ceased' to allow for periods of leave. Ensure all weeks spent providing services in each quarter are captured. You need to complete this form for at least four quarters, regardless of whether you were participating in Health Care Homes in every quarter.

New participants to the GPRIP who are practising predominantly in MM3-5 locations will need eight active quarters within a 16 quarter period in order to qualify for an initial GPRIP payment. If this applies to you, you can add additional activity tables to this form.

HELP WITH THIS FORM: If you have any questions when completing this form, including which quarters to include, please contact gprip@health.gov.au for assistance. For information about what services are considered eligible under the GPRIP, please refer to the GPRIP Program Guidelines.

WHAT'S NEXT: After you submit this form to gprip@health.gov.au, you will receive an acknowledgement email within 1-3 business days. The Department of Health will review your activity using the information below in combination with MBS billing data and any relevant GPRIP payment history. You will be notified of the outcome of this review via email. If the outcome of this review process determines you are eligible for a further payment, Human Services will process the payment to your nominated bank account for the GPRIP.

Ensure that Human Services has your up-to-date bank details, specifically for the GPRIP by filling in the GPRIP Bank Details Form on the Department of Human Services Website or using Health Professional Online Services (HPOS).

Payment Quarters
Payments are determined by activity within quarters.

Quarter One – July, August, September
Quarter Two – October, November, December
Quarter Three – January, February, March
Quarter Four – April, May, June

Name:	
Provider Number:	
Health Care Homes Practice ID:	
Health Care Homes Practice Name and Address:	
Contact Email Address:	

QUARTER NUMBER:_____	**YEAR:____**		**Did you provide services to Health Care Homes patients in this quarter?: Circle: YES / NO**	
Practice location/Address	**Date commenced**	**Date ceased**	**Name of Practice/Organisation**	**Total Average Hours Per Week (<u>all</u> GPRIP Eligible Primary Care Services)**
Practice Manager / Employer Name: _____	**Signature of Practice Manager / Employer :** _____ *Signing this section indicates that information in the table above is accurate and reflected in records to the best of the signatory's knowledge.*			

QUARTER NUMBER:_____	**YEAR:____**		**Did you provide services to Health Care Homes patients in this quarter?: Circle: YES / NO**	
Practice location/Address	**Date commenced**	**Date ceased**	**Name of Practice/Organisation**	**Total Average Hours Per Week (<u>all</u> GPRIP Eligible Primary Care Services)**
Practice Manager / Employer Name: _____	**Signature of Practice Manager / Employer :** _____ *Signing this section indicates that information in the table above is accurate and reflected in records to the best of the signatory's knowledge.*			

QUARTER NUMBER:_____	**YEAR:____**	**Did you provide services to Health Care Homes patients in this quarter?: Circle: YES / NO**

Practice location/Address	Date commenced	Date ceased	Name of Practice/Organisation	Total Average Hours Per Week (all GPRIP Eligible Primary Care Services)
Practice Manager / Employer Name: _____	**Signature of Practice Manager / Employer :** _____ *Signing this section indicates that information in the table above is accurate and reflected in records to the best of the signatory's knowledge.*			

QUARTER NUMBER:_____	**YEAR:____**		**Did you provide services to Health Care Homes patients in this quarter?: Circle: YES / NO**	
Practice location/Address	**Date commenced**	**Date ceased**	**Name of Practice/Organisation**	**Total Average Hours Per Week (all GPRIP Eligible Primary Care Services)**
Practice Manager / Employer Name: _____	**Signature of Practice Manager / Employer :** _____ *Signing this section indicates that information in the table above is accurate and reflected in records to the best of the signatory's knowledge.*			

Note: If you are a new participant to the GPRIP and practising predominantly in MM3-5 locations, you may need to add additional tables to cover a period of eight quarters. Refer to the GPRIP Program Guidelines for more information on whether this applies to you.

SELF-DECLARATION

Please read and understand the following statements and sign below, prior to submitting this form:

I declare that:

- The activity I have recorded relates only to GPRIP eligible services provided in MM 3 to 7 locations, during the quarter periods as stated above.
- I understand that it is my responsibility to ensure that the information provided is true and accurate.

_____ _____ _____

Medical Practitioner Name Medical Practitioner Signature Date