



# Residential Medication Management Review (RMMR) multi-lodgement claim form



(One claim form should be completed for each accredited pharmacist providing RMMR services)

Name of approved RMMR service provider

Pharmacy approval number or program ID number

Phone number

 ( )

Name of aged care home

Aged care service ID

Name of accredited pharmacist (if the same as the service provider, write 'as above')

Accreditation number (on certificate)

Claimant's reference number

If you require assistance to complete this form  
call Medicare Australia on **08 8274 9641**

Complete one line for each service

Medicare/DVA number (insert all numbers)	Patient's family name	Patient's first given name	Patient's date of birth	RMMR review date	Type of service ✓ whichever		Please complete where collaborative		
					Pharmacist	Collaborative	Referral obtained Yes No	Provider number of requesting general practitioner (GP)	Name of requesting GP
			/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

I certify that the details on this form are true and correct and that the RMMR services being claimed were conducted in accordance with the program application and terms and conditions.

I certify that quality use of medicine (QUM) activities have been undertaken and details are included in the QUM quarterly report.

Mail the completed form to:

Community Pharmacy Agreement officer  
Medicare Australia  
GPO 9826  
Adelaide SA 5001

Signature of accredited  
pharmacist (must sign twice if  
accredited pharmacist is the same  
as approved service provider)

Signature of  
approved RMMR  
service provider

Date

 / /

Signature of  
Director of Nursing

Date

 / /

Name

**Privacy Note:** The information provided by you on this form will be used to assess your claim for Residential Medication Management Reviews and associated Quality Use of Medicines services, and if approved, for maintaining Medicare Australia's pharmacy approvals database. Its collection is authorised under the *National Health Act 1953* and may be disclosed to the Department of Human Services, Department of Health and Ageing or where authorised or required by law.