Pharmacy Relocation – DAA Cap Reinstatement Request

When Service Providers participating in the Dose Administration Aids (DAA) Program undergo a change of location, their weekly DAA claiming cap is reverted to the base cap of 90 patients per week.

Each DAA cap reinstatement request will be considered based on the information provided below. Some requests may need to be sent to the Department of Health, Disability and Ageing via the Exceptional Circumstances process. Should your case be sent to the Department as an exceptional circumstances request, you will receive an exceptional circumstances reference code via email shortly.

Please note that the DAA cap relocation process is only applicable to Service Providers that have moved location. It is not to be used by Service Providers seeking to increase their weekly DAA cap for any other reason. Service Providers are reminded that requests for an increased DAA cap for general uptake in the service, are not permitted. Requests received by the PPA that are not a DAA cap reinstatement request due to a location change will not be considered.

Please complete this form and email to **support@ppaonline.com.au.** A decision regarding your DAA cap will be emailed to the Main Authorised Person for the Service Provider listed on the PPA Portal.

Name of pharmacy ……………………………………………………………………………………….

New PBS Approval Number …………………………………………………………………………..

Old PBS Approval Number …………………………………………………………………………..

Date of relocation: ……………………………………………………………………………………..

Old address: Street: ………………………………………………………………………………………

Town/City ……………………………………………………………………………………

State: ……………………………………………………………………………………..

Postcode: ……………………………………………………………………………………

New address: Street: ………………………………………………………………………………………

Town/City ……………………………………………………………………………………

State: ……………………………………………………………………………………..

Postcode: ……………………………………………………………………………………

Distance of location change (in metres according to Google Maps): ……………………………………………………

Are you still servicing the same DAA clientele? ……………………………………………………

Please list any additional information relating to your request

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[ text box ]
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By submitting this form, you agree that the information provided is true and correct and that you are able to support this declaration with appropriate evidence should the Service Provider be audited in relation to this request. This form must be completed and signed by the Main Authorised Person of this Service Provider as listed in the PPA Portal.

Signature		Date	