Fiona Stanley Hospital

PATIENT ENTERTAINMENT - REFUND FORM

***** REFUNDS ARE ONLY PROVIDED FOR AVAILABLE ACCOUNT BALANCES OF $5 AND ABOVE *****

Please complete **all 4 steps below** and mail the signed form (and the PES card if still in your possession) to:

Patient Entertainment Service Refund
Accounts Payable – Fiona Stanley Hospital
PO Box 2142, KARDINYA, WA, 6163

Reimbursement Methods

In accordance with national credit legislation, the Reimbursement method used for refund will vary depending on the method you have used to add funds to your PES account.

If you have not used credit at any time to add funds, your refund will be issued by bank deposit to the account you nominate on the PES Refund Request Form.

Refund Processing Times

All fields shaded in grey are mandatory and must be completed.

Complete and accurate refund forms will be refunded to the nominated bank account within 28 days of receipt.

Step 1 ## Account Holder Details

Full Name	
Postal or Email Address	
Contact Phone Number	**Home: ( )** **Mobile:**

Step 2 ## Entertainment Account Details

Patient Name and UMRN. - Mandatory *Your Unique Medical Record Number (UMRN) can be found contained within correspondence received from WA Health or written on your wrist band.*	**Patient Name:** _____ UMRN: __ __ __ __ __ __ __ __ __
Original Payment Method	Circle Applicable: **Cash** | **Credit Card** | **Debit Card**

Step 3 ## Donation or Refund

Donation Donate your remaining account balance to Fiona Stanley Hospital	If you wish to donate the remaining account balance, please tick "I wish to donate" below and move to **Step 4** ☐ **I WISH TO DONATE**

Refund Details Please select either bank account or credit card for refund. Please note: If the original payment was by credit card, this refund **must** be to the same credit card using the BPAY information found on your Credit Card statement	Bank Account BSB: __ __ __ - __ __ __ Account Name: _____ Account Number: _____ Bank and Branch: _____ **OR** Your BPAY Biller Code: _____ Your BPAY Reference Number: _____

Step 4

I confirm that the information provided above is accurate and acknowledge that Fiona Stanley Hospital will determine the final balance on the card and are not liable for any incorrect information including incorrect banking or credit card details that are provided.

Name:_____ Signature: _____ Date: _____

Office Use Only:

Received:	Processed:	
Authorised:	Reference:	Amount: