– If completing by hand please use BLACK PEN –

medicare **ASSIGNMENT FORM** (This form is the approved form as prescribed under section 20A of the *Health Insurance Act 1973*) DB4E

PATIENT DETAILS

FIRST NAME ..... INITIAL .....

SURNAME .....

RESIDENTIAL ADDRESS .....

.....

DATE OF BIRTH DD / MM / YYYY ..... EXPIRY DATE CHECKED [X]

MEDICARE NUMBER

PERIOD OF REFERRAL IN MONTHS (MM) OR CROSS IF INDEFINITE [X] REFERRAL OR REQUEST DATE (DD/MM/YY) / /

REFERRING OR REQUESTING PRACTITIONER PROVIDER No.

NAME & ADDRESS OF REQUESTING/REFERRING PRACTITIONER

LSPN

EQUIPMENT NUMBER

SCP

PRACTITIONER USE

PATIENT REF. No.

DATE OF SERVICE DD / MM / YY / /

DESCRIPTION OF SERVICE	ITEM NO.	S/D	BENEFIT ASSIGNED
			.
			.
			.
			.
			.
			.
			.
			.
			.
			.
			.

I assign/offer to assign my right to benefits to the practitioner who has rendered the service(s), or in the case of requested pathology, the approved pathology practitioner who will render the requested pathology service(s).

SIGNATURE OF PATIENT ..... / / DATE

NAME & PROVIDER No. OR ADDRESS OF PRACTITIONER WHO RENDERED THE ABOVE SERVICE(S)

DB4E(a).1405

Save Reset Print

Practitioner copy

– If completing by hand please use BLACK PEN –

medicare **ASSIGNMENT FORM** (This form is the approved form as prescribed under section 20A of the *Health Insurance Act 1973*) DB4E

PATIENT DETAILS

FIRST NAME ..... INITIAL .....

SURNAME .....

RESIDENTIAL ADDRESS .....

.....

DATE OF BIRTH DD / MM / YYYY ..... EXPIRY DATE CHECKED [X]

MEDICARE NUMBER

PERIOD OF REFERRAL IN MONTHS (MM) OR CROSS IF INDEFINITE [X] REFERRAL OR REQUEST DATE (DD/MM/YY) / /

REFERRING OR REQUESTING PRACTITIONER PROVIDER No.

NAME & ADDRESS OF REQUESTING/REFERRING PRACTITIONER

LSPN

EQUIPMENT NUMBER

SCP

PRACTITIONER USE

PATIENT REF. No.

DATE OF SERVICE DD / MM / YY / /

DESCRIPTION OF SERVICE	ITEM NO.	S/D	BENEFIT ASSIGNED
			.
			.
			.
			.
			.
			.
			.
			.
			.
			.
			.

I assign/offer to assign my right to benefits to the practitioner who has rendered the service(s), or in the case of requested pathology, the approved pathology practitioner who will render the requested pathology service(s).

SIGNATURE OF PATIENT ..... / / DATE

NAME & PROVIDER No. OR ADDRESS OF PRACTITIONER WHO RENDERED THE ABOVE SERVICE(S)

DB4E(a).1405

Patient copy

Privacy and your personal information
Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim. Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law. You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at **humanservices.gov.au/privacy** or by requesting a copy from the department.