Patient details

First given name ..... Initial .....

Family name .....

Residential address .....

.....

Date of birth (DD MM YYYY) ..... Expiry date checked [X]

Medicare card number

Period of referral in months (MM) **or** cross if indefinite [X]

Referral or request date (DD MM YY) / /

In-hospital referral No ☐ Yes ☐

Referring or requesting practitioner provider number

Full name and address of requesting or referring practitioner

Location Specific Practice Number

Equipment number

SCP

Is the assignor the patient? No ☐ Yes ☐

Agreement type: Post-assignment ☐ Assignor must sign and date below

I 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).

On completion of this form, print and sign by hand

Assignor's signature Date (DD MM YYYY) / /

medicare

ASSIGNMENT FORM

DB4E(a)

Patient ref no.

Date of service, imaging procedure or first specimen collection (DD MM YY) / /

Description of service	Item number	S/D	Benefit assigned
			.
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			.
			.
			.
			.
			.
			.
			.
			.

Full name and provider number or address of practitioner who rendered the above service(s)

DB4E(a).2607

Reset

Practitioner copy

Patient details

First given name ..... Initial .....

Family name .....

Residential address .....

.....

Date of birth (DD MM YYYY) ..... Expiry date checked [X]

Medicare card number

Period of referral in months (MM) **or** cross if indefinite [X]

Referral or request date (DD MM YY) / /

In-hospital referral No ☐ Yes ☐

Referring or requesting practitioner provider number

Full name and address of requesting or referring practitioner

Location Specific Practice Number

Equipment number

SCP

Is the assignor the patient? No ☐ Yes ☐

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Assignor's signature Date (DD MM YYYY) / /

medicare

ASSIGNMENT FORM

DB4E(a)

Patient ref no.

Date of service, imaging procedure or first specimen collection (DD MM YY) / /

Description of service	Item number	S/D	Benefit assigned
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Full name and provider number or address of practitioner who rendered the above service(s)

DB4E(a).2607

Patient copy

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