

PATIENT DETAILS

PATIENT'S FULL NAME

DATE OF BIRTH (DD/MM/YYYY) EXPIRY DATE CHECKED

MEDICARE NUMBER

PERIOD OF REFERRAL IN MONTHS (MM) REFERRAL OR REQUEST DATE (DD/MM/YY)

CROSS IF INDEFINITE IN-HOSPITAL REFERRAL NO YES

REFERRING OR REQUESTING PRACTITIONER PROVIDER NUMBER

NAME AND ADDRESS OF REQUESTING/REFERRING PRACTITIONER

LSPN

EQUIPMENT NUMBER

SCP

NUMBER OF PATIENTS ATTENDED

PRACTITIONER USE

I assign my right to benefits to the Practitioner who rendered the service(s) or I offer to assign my right to benefits to the approved Pathology Practitioner who will render the requested pathology service(s).



SIGNATURE OF PATIENT

DATE



Australian Government
Services Australia

For use with Medicare Bulk Bill Webclaim only

(This form is the approved form as prescribed under section 20A of the Health Insurance Act 1973)



PATIENT REF NUMBER

DATE OF SERVICE (DD/MM/YY)

DESCRIPTION OF SERVICE	ITEM NUMBER	IN-HOSPITAL SERVICE * or S/S	S/D	BENEFIT ASSIGNED

Practitioner copy

DB020.2006



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Patient copy

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