PATIENT DETAILS

PATIENT'S FULL NAME .....

.....

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

MEDICARE NUMBER

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

OR

CROSS IF INDEFINITE [X] 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

medicare

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 *	S/D or S/S	BENEFIT ASSIGNED
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.

NAME AND PROVIDER NUMBER OR ADDRESS OF PRACTITIONER WHO RENDERED/WILL RENDER THE ABOVE SERVICE(S)

PATIENT IS UNABLE TO SIGN ☐

DB020.2006

Reset

Practitioner copy

PATIENT DETAILS

PATIENT'S FULL NAME .....

.....

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

MEDICARE NUMBER

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

OR

CROSS IF INDEFINITE [X] IN-HOSPITAL REFERRAL NO ☐ YES ☐

REFERRING OR REQUESTING PRACTITIONER PROVIDER NUMBER

NAME AND ADDRESS OF REQUESTING/REFERRING PRACTITIONER

LSPN

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NUMBER OF PATIENTS ATTENDED

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PATIENT REF NUMBER

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		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.
		[X]		.

NAME AND PROVIDER NUMBER OR ADDRESS OF PRACTITIONER WHO RENDERED/WILL RENDER THE ABOVE SERVICE(S)

PATIENT IS UNABLE TO SIGN ☐

DB020.2006

Patient copy

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