PATIENT DETAILS

(3a)

PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN

FULL NAME

DATE OF BIRTH / / (3b)

ADDRESS

File number if imprinter not used (3c)

Description of requested pathology (4)

CERTIFICATION

I certify that I have received the services described on this voucher, or, the Practitioner has requested Pathology tests for me. I am not entitled to claim third party or worker's compensation for these services.

Patient's Signature (12a)

Or I certify – X The patient is unable to sign (12b) X The service is associated with an emergency (12c)

Provider's Signature

D1216G (Design date 02/08) – Triplicate – Claimant copy (2)

Commonwealth Department of Veterans' Affairs (1) 66

AB32101

General Practitioner Treatment Service Voucher

(5) Date of Service DD / MM / YY: / /

DESCRIPTION OF SERVICE	ITEM NO.	X	AMOUNT CLAIMED
Consultation Level B	23 (6a)	X	(6c) .
Consultation Level C	36	X	.
Standard Consultation	53	X	.
(6b)			.
			.

(9) Number of kilometres travelled (10a) Number of patients attended

Name of Hospital or Nursing Home (if applicable) (10b)

Condition treated (White card holders and emergencies only) (11)

(7) Name of Practitioner who rendered the services (8) Practitioner use