PATIENT DETAILS

– PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN –

REF. No | FIRST NAME | INITIAL | SURNAME

DATE OF BIRTH

RESIDENTIAL ADDRESS

VALID TO DATE CHECKED

Medicare 81 ASSIGNMENT FORM

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

DB2-GP

PATIENT REF. No. | DATE OF SERVICE DD / MM / YY   /   /

DESCRIPTION OF SERVICE	ITEM NO.	X	BENEFIT ASSIGNED
CONSULTATION: LEVEL A	3		
CONSULTATION: LEVEL B	23		
CONSULTATION: LEVEL C	36		
STANDARD CONSULTATION	53		
			.
			.

MEDICARE NUMBER IF IMPRINTER NOT USED

PRACTITIONER USE

I assign my right to benefits to the practitioner who has rendered the service(s).

X

SIGNATURE OF PATIENT   DATE   /   /

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

No. OF PATIENTS ATTENDED

MEDICARE COPY

Designed 03/06 Printed /06

HOLD BOTH ENDS FIRMLY – PULL TO SEPARATE

ASSIGNMENT FORM No

PATIENT DETAILS

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PATIENT COPY

Designed 03/06

HOLD BOTH ENDS FIRMLY – PULL TO SEPARATE

ASSIGNMENT FORM No