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 1 1 7 7 2

EQUIPMENT NUMBER 4 7 0 1 9 8

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 ☐

Practitioner copy

DB020.2006

Reset

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 1 1 7 7 2

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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 ☐

Patient copy

DB020.2006