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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 .....

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 / /



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) .....

Table with columns: DESCRIPTION OF SERVICE, ITEM NUMBER, IN-HOSPITAL SERVICE \* or S/S, S/D, BENEFIT ASSIGNED

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



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Patient copy

DB020.2006

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