PATIENT DETAILS

FIRST NAME .... INITIAL ......

SURNAME ....

RESIDENTIAL ADDRESS ....

DATE OF BIRTH DD / MM / YYYY .... EXPIRY DATE CHECKED X

MEDICARE NUMBER

medicare **ASSIGNMENT FORM** (This form is the approved form as prescribed under section 20A of the *Health Insurance Act 1973*) **DB4E**

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

DESCRIPTION OF SERVICE	ITEM NO.	S/D	BENEFIT ASSIGNED
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PERIOD OF REFERRAL IN MONTHS (MM) OR CROSS IF INDEFINITE X

REFERRAL OR REQUEST DATE (DD/MM/YY) __ / __ / __

REFERRING OR REQUESTING PRACTITIONER PROVIDER No.

NAME & ADDRESS OF REQUESTING/REFERRING PRACTITIONER

LSPN

EQUIPMENT NUMBER

SCP

PRACTITIONER USE

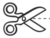
I assign/offer to assign my right to benefits to the practitioner who has rendered the service(s), or in the case of requested pathology, the approved pathology practitioner who will render the requested pathology service(s).

SIGNATURE OF PATIENT .... DATE / /

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

Practitioner copy

DB4E(a).230911



PATIENT DETAILS

FIRST NAME .... INITIAL ......

SURNAME ....

RESIDENTIAL ADDRESS ....

DATE OF BIRTH DD / MM / YYYY .... EXPIRY DATE CHECKED X

MEDICARE NUMBER

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

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PERIOD OF REFERRAL IN MONTHS (MM) OR CROSS IF INDEFINITE X

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SIGNATURE OF PATIENT .... DATE / /

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

Patient copy

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