

– PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN –

DETAILS OF SERVICE DENTAL PRACTITIONER

Name []
Address []
Postcode []
Service provider/provider number []



CLAIM FOR ASSIGNED BENEFITS FOR SERVICES RENDERED TO NON-HOSPITAL PATIENTS. (This form is the approved form as Medicare prescribed under section 20B 2 (a) of the Health Insurance Act 1973)

DB1N-DP

Date of claim [/ /] Claim number []
Number of assignment forms []
Total benefit amount claimed \$ []

MEDICARE COPY

DECLARATION BY DENTAL PRACTITIONER WHO RENDERED THE SERVICES

I claim Medicare benefits, being the amount specified in the column headed "Benefit Assigned", in respect of all the professional services specified in the attached assignment forms or claims transmission summary sheet, and I declare that:
• I authorise Medicare to pay benefits in respect of the attached assignment forms or claims transmission summary sheet, to the Dental Practitioner specified below at or from whose practice the services were rendered*.

- A copy of the assignment form was given to the assignor(s) after the right to benefit was assigned.
• No payments have been sought from any person in respect of the services specified in the attached assignment forms and claims transmission summary sheet.
• None of the amounts claimed is in respect of a service –
(a) that was rendered to an in-patient of a hospital or approved day hospital facility;
(b) that was rendered in carrying out a mass immunisation, in connection with the patient's employment or in carrying out health screening (other than by providers approved by the Minister for Health and Ageing);
(c) that was a medical examination for the purposes of Life Insurance, a Superannuation or Provident Account Scheme or admission to membership of a Friendly Society; or
(d) which is precluded from Medicare benefit by any provision of the Health Insurance Act 1973.

IMPORTANT

Only complete this section if the payment is to be made to an Dental Practitioner other than the service Dental Practitioner.

*Print name of Dental Practitioner []

Payee provider/provider number []

- To the best of my knowledge and belief all information contained in this claim is true.
• I accept the assignments in this claim.
• The professional services specified on the attached assignment forms or claims transmission summary sheet, were provided by me or on my behalf.
• To the best of my knowledge and belief the assignor(s) in respect of whom assignments have been accepted are entitled to make such assignments under Section 20A of the Health Insurance Act 1973.

Signature of Dental Practitioner who rendered the services



Signature of Witness to above signature



Printed name of Witness

Date

[] [/ /]

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DENTAL PRACTITIONER COPY

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Printed name of Witness

Date

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