

- **IMPORTANT** — When completing a DB1N form:
 - use a **black ballpoint pen**
 - do not submit **mixed batches** of DB2, DB3, DB4 and DB5 forms
 - to avoid problems with the processing of vouchers please ensure you clearly mark within the specified areas.

EXAMPLE

1	2	3	4	5
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 OR

1	2	/	0	2	/	9	7
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 OR

X

- This form is only used to claim assigned Medicare benefits for services rendered by an allied health professional from a single practice location.
- The following steps should be taken when completing this form:
 - Remove the cover sheet and clearly write the allied health professional's name and number in the relevant spaces. (**Note:** if the service allied health professional does not have a provider number for the practice address from which the services were rendered, e.g. temporary locum, the provider number of another practice address is acceptable.)
 - Complete all other sections such as date of claim, number of forms (no more than 80 vouchers should be contained in each claim) and amount claimed.
 - Where payment is to be made to an allied health professional other than the service allied health professional ensure the PAYEE ALLIED HEALTH PROFESSIONAL section is completed. (This is not necessary where a paygroup link facility has been set up.)
 - The service allied health professional must sign the form and have the signature witnessed in the relevant section.
 - Place the form at the front of the batch of vouchers that make up this claim (please do not use staples to attach these forms).
 - It is an offence under the *Health Insurance Act 1973* to make a false statement relating to Medicare benefits.

02.05.08

– PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN –

DETAILS OF SERVICE ALLIED HEALTH PROFESSIONAL

NAME

ADDRESS

SERVICE PROVIDER / PROVIDER NUMBER

medicare

33

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

DB1N-AH

DATE OF CLAIM DD / MM / YY

CLAIM NUMBER

NUMBER OF ASSIGNMENT FORMS

TOTAL BENEFIT AMOUNT CLAIMED

\$

DECLARATION BY ALLIED HEALTH PROFESSIONAL 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 Allied Health Professional specified below at or from whose practice the services were rendered.*

IMPORTANT Only complete this section if the payment is to be made to an allied health professional other than the service allied health professional.

* Print name of Allied Health Professional

PAYEE PROVIDER / PROVIDER NUMBER

- 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 –
 - that was rendered to an in-patient of a hospital or approved day hospital facility;
 - 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);
 - 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
 - which is precluded from Medicare benefit by any provision of the *Health Insurance Act 1973*.

Signature of Allied Health Professional who rendered the services _____

Signature of Witness to above signature _____

Printed name of Witness _____ Date _____

- 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 20A of the *Health Insurance Act 1973*.

02.05.08

HOLD BOTH ENDS FIRMLY – PULL TO SEPARATE
MEDICARE COPY

– PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN –

DETAILS OF SERVICE ALLIED HEALTH PROFESSIONAL

NAME

ADDRESS

SERVICE PROVIDER / PROVIDER NUMBER

medicare

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PRACTITIONER COPY