

DO NOT REMOVE COVER SHEET BEFORE IMPRINTING

1. Only one patient is allowed per form.
2. Check date of service is before expiry date by placing an **X** in the box provided.
3. A Card with VISITOR RHCA indicates Medicare will only pay benefits for IMMEDIATELY NECESSARY MEDICAL CARE.
4. When completing the voucher use the following steps:
 - (a) Imprint the Medicare Card
 - (b) Remove this cover sheet
 - (c) Complete the relevant sections of the forms making sure information entered into a box is completely within the box. EXAMPLE

1	2	3	4	5
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 OR

1	2	/	0	2	/	0	6
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 OR

X

5. If the service is one which has been self determined, place a **D** in the indicated area alongside the item.
If the service is a diagnostic imaging service that has been substituted for a requested service, place a **S** in the indicated area alongside the item.
6. Patient **MUST** sign the form **AFTER** the form has been completed.
7. Send the **RED** copy to Medicare, keep the **BLACK** copy for your records and give the **GREEN** copy to the patient.

PRIVACY NOTE: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of Australian Government health programs and may be used to update enrolment records. Its collection is authorised by provisions of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health and Ageing, Department of Human Services, Centrelink, other relevant agencies or to a person in the medical practice associated with this claim or as authorised/required by law.

- PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN -

PATIENT DETAILS

REF. No. FIRST NAME INITIAL SURNAME

DATE OF BIRTH

RESIDENTIAL ADDRESS

EXPIRY DATE CHECKED

Medicare **98** **ASSIGNMENT FORM** (This form is the approved form as prescribed under section 20A of the Health Insurance Act 1973) **DB2-OT**

PATIENT REF. No.	DATE OF SERVICE DD / MM / YY				
S/D	DESCRIPTION OF SERVICE	ITEM NO.	BENEFIT ASSIGNED		
PERIOD OF REFERRAL IN MONTHS (MM)	REFERRAL OR REQUEST DATE (DD/MM/YY)				
OR CROSS IF INDEFINITE <input checked="" type="checkbox"/>	REFERRING OR REQUESTING PRACTITIONER PROVIDER No.				
NAME & ADDRESS OF REQUESTING/REFERRING PRACTITIONER					
I 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).					
NAME & PROVIDER No. OR ADDRESS OF PRACTITIONER WHO RENDERED THE ABOVE SERVICE(S)				PRACTITIONER USE	
SIGNATURE OF PATIENT				DATE	

MEDICARE COPY Designed 03/06 Printed /06

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PATIENT COPY Designed 03/06

HOLD BOTH ENDS FIRMLY - PULL TO SEPARATE

A S S I G N M E N T F O R M N O