Medicare

ASSIGNMENT FORM FOR USE BY PATHOLOGISTS ONLY

DB3

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
5. Complete all relevant sections relating to the services rendered, or if the patient is offering to assign benefit for pathology, provide a brief description of the requested pathology.
6. If the service is one which has been self determined, place an **X** in the indicated area alongside the item.
7. Patient MUST sign the form AFTER the form has been completed.
8. Send the YELLOW copy to Medicare, keep the BLACK copy for your records and give the GREEN copy to the patient.

PATHOLOGISTS

Designed 03/06

PATIENT DETAILS

MEDICARE NUMBER

REF No. FIRST NAME INITIAL SURNAME

DATE OF BIRTH ....

RESIDENTIAL ADDRESS

....

Medicare FOR PATHOLOGY SERVICES ONLY DB3

(This form is the approved form as prescribed under section 20A of the *Health Insurance Act 1973*.)

TO BE COMPLETED BY THE PERSON ASSIGNING BENEFITS FOR THE SERVICES IN THIS FORM

- I ASSIGN/OFFER TO ASSIGN MY RIGHT TO BENEFITS TO THE PRACTITIONER WHO RENDERED/WILL RENDER THE PATHOLOGY SERVICES ITEMISED /DESCRIBED BELOW

SIGNATURE X .... DATE .... /.......... / ....

OR • OFFER TO ASSIGN FORM No. .... IS ATTACHED

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.

DESCRIPTION CODE	Date of Service			SD	ITEM NUMBER	BENEFIT ASSIGNED
	DATE	MTH	YEAR			

REQUESTING PRACTITIONER DETAILS

NAME ....

PROVIDER No. ....

DATE OF REQUEST ..../.........../..........

DESCRIPTION OF REQUESTED PATHOLOGY

NAME OF APP RESPONSIBLE FOR TESTS...

PROVIDER No. OR ADDRESS

....

PRACTITIONER USE

HOLD BOTH ENDS FIRMLY – PULL TO SEPARATE

MEDICARE COPY

Designed 03/06 Printed /06

PATIENT DETAILS

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DATE OF BIRTH ....

RESIDENTIAL ADDRESS

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