



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

TO BE COMPLETED BY THE PERSON ASSIGNING OR OFFERING TO ASSIGN BENEFITS FOR THE SERVICES IN THIS FORM
(PLEASE PLACE AN "X" IN THE APPROPRIATE BOX)

- I ASSIGN MY RIGHT TO BENEFITS TO THE PRACTITIONER WHO RENDERED THE SERVICES
- OR**
- I OFFER TO ASSIGN MY RIGHT TO BENEFITS TO THE APPROVED PATHOLOGY PRACTITIONER WHO WILL RENDER THE REQUESTED PATHOLOGY SERVICES.

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

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.

PRACTITIONER USE

PATIENT DETAILS

MEDICARE NUMBER	REF. No.	FIRST NAME	INITIAL	SURNAME	DATE OF BIRTH
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RESIDENTIAL ADDRESS

DATE OF SERVICE	DESCRIPTION OF SERVICE	ITEM No.	BENEFIT ASSIGNED	DESCRIPTION OF REQUESTED PATHOLOGY

REQUESTING/REFERRING PRACTITIONER'S NAME	IF THE SERVICE IS ONE WHICH HAS BEEN SELF DETERMINED, PLACE A "D" BELOW. IF THE SERVICE IS A DIAGNOSTIC IMAGING SERVICE THAT HAS BEEN SUBSTITUTED FOR A REQUESTED SERVICE, PLACE A "S" BELOW.	NAME OF PRACTITIONER WHO RENDERED THE ABOVE SERVICES
PROVIDER No. OR ADDRESS		PROVIDER No. OR ADDRESS
DATE OF REFERRAL		PERIOD OF REFERRAL



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