



## Certification of Cleft Condition

Prescribed Dental Patient

- Please print, complete and make two copies
- Original to be retained by the patient
- One copy to be retained by the clinic/practitioner
- One copy to be posted to:  
Medicare Australia  
PO Box 9822  
Perth WA 6848

Full name of practitioner

I

Address of Practice

of

being an approved medical practitioner or dental practitioner as referred to in the definition of 'prescribed dental patient' in section 3BA of the *Health Insurance Act 1973* certify that:

Given Names

Family Name

*(full name of patient)*

of  Postcode

*(full address)*

is suffering from a

cleft lip condition

cleft palate condition

cleft lip and cleft palate condition

other condition for consideration  please specify

Signature of approved Medical Practitioner or dental Practitioner

Date / /

## Certificate of date of birth of patient

To be completed by Parent/Guardian *(or Patient, if 18 years or over)*

Name of patient

I certify that

was born on the  Day of  19

Medicare Number

Name of person signing

Relationship to patient

Signature  Date / /