

Section 5

Billing and claiming

Billing

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Billing and claiming

Billing

Practitioners have two choices for billing services. They can bill patients privately or bulk bill Medicare (assignment of benefit).

Required details

Regardless of which billing method is chosen, the following details are required on each account, receipt or bulk bill voucher submitted to Medicare:

- practitioner's name, address and/or provider number
- patient's name (in the case of family names indicate senior/junior)
- Medicare Benefits Schedule (MBS) item number and a description of the service or a description of the service sufficiently detailed to enable the correct MBS item to be identified
- date of service
- the amount charged
- identification of in-hospital services
 - patient account: an asterisk (*) or the word "admitted patient" beside the appropriate item number
 - bulk bill: attach the vouchers to a DB1H claim header (see Form DB1N).

The following details may also need to be shown on the account.

- Accounts from consultant physicians and specialists
 - referral details (name, address and/or provider number of the referring practitioner)
 - date of referral and the period of referral, preferably in months or "indefinite" if applicable.
- Diagnostic imaging services
 - name, address and/or provider number of the practitioner who provided the report.
- Diagnostic imaging where exemption is claimed from request requirements
 - the account should be annotated "SD" (self-determined).
- "R-type" diagnostic imaging services
 - name, address and/or provider number of the requesting practitioner and the date of request.
- Requested pathology services
 - name of the requesting provider, provider number and the date of request. If the service is self-determined for the practitioner's own patient, the account should be annotated "SD".

- Administration of an anaesthetic or assistance at an operation
 - name of the surgeon and the item number relating to the operation.
- Patient is attended on more than one occasion in any day
 - time when each attendance occurred on separate vouchers (if bulk billed), each signed by patient.
- Category 1 attendance items endorsement
 - notification of “not normal aftercare” – NNAC.
- Category 5 diagnostic imaging items endorsement
 - notification of “not for comparison” – NFC along with description i.e. L foot, R foot etc. (For example, online claiming = HX1)
- Category 6 pathology items endorsement
 - notification of “Rule 3 Exemption” or S4B3.
- Specialist/consultant referrals or diagnostic imaging services where the referral/request was lost or destroyed or the service was provided in an emergency
 - notification of “lost referral” or “emergency referral”.

Claiming from Medicare—patient

The settlement of a private account is the responsibility of the patient (claimant). When you bill a claimant they can either:

- pay the full amount of the consultation and use their detailed receipt to claim a Medicare benefit
- pay the difference between the Medicare benefit and the total account amount, and then claim the benefit from Medicare to forward to the doctor later
- claim from Medicare using their unpaid account.

Please ensure the account clearly indicates whether or not it has been paid.

Paid account

If the account has been paid, claimants can obtain a cash benefit (up to certain limits) from a Medicare office. Alternatively they can lodge a claim by post, by Medicare claiming facilities available in some rural locations, or telephone (also in rural areas throughout Australia) for a payment by electronic funds transfer (EFT) or cheque.

From the second half of 2007, patients who pay their account can use Medicare Easyclaim to receive their Medicare benefit directly into a nominated bank account, through the EFTPOS terminal at participating practices. After they have paid their account, patients can lodge their Medicare claim by swiping their Medicare card through the surgery’s EFTPOS terminal. The rebate will be paid into the patient’s bank account almost instantly.

For more information about Medicare Easyclaim visit the Medicare Australia web site.

Unpaid account

If the account is unpaid, the claimant can submit the claim for a cheque benefit made payable to the medical provider and posted to the claimant. This can be done using the same methods as for paid accounts. The claimant is then responsible for settling the practitioner's account.

These cheques are mailed in accordance with the Australian Government's minimum payment times. Allowances must also be made for time taken by the claimant to lodge the claim, the time in which the claim and the cheque are in the mail system, and any delays by the claimant in finalising payment after the cheque has been received.

From the second half of 2007, patients who have an unpaid account can use Medicare Easyclaim to submit the claim for a cheque benefit made payable to the provider through the EFTPOS terminal at participating practices. After the consultation, the patient's Medicare card is swiped through the surgery's EFTPOS terminal and a claim is lodged. A cheque is then posted directly to the patient, speeding up the process and providing certainty that the patient has lodged the claim.

For more information about Medicare Easyclaim visit the Medicare Australia web site.

Where the claimant has been given a "pay doctor via claimant" cheque, Medicare Australia can release claims information relating to the services connected with the cheque to the provider. The provider must be able to identify the service(s) that the cheque relates to.

If there is a dispute between the claimant and the provider regarding the payment of an account Medicare Australia can release the presentation date, account name, financial institution and the cheque amount to the provider if the cheque has been banked.

Note: Medicare Australia cannot disclose the account number to the provider.

It is important that patients keep their address details up-to-date with Medicare, as the cheque will be posted to the address recorded. Patients can update their address details:

- online—www.medicareaustralia.gov.au
- in person—at any Medicare office
- over the phone—phone **132 011***.

Submitting private (patient) claims electronically

If your practice has online claiming, claimants are able to lodge their Medicare claims electronically from your practice. Online claiming uses demographic billing information already stored in your practice management system to create an electronic claim. With permission, the claim is forwarded to Medicare Australia via the Internet.

If the claim is error free, it is processed and payment is made according to the minimum payment timeframes. The system can be used in real-time or store-and-forward mode. Any errors found in transactions will be returned for correction and retransmission.

* Local call rates. Normal mobile and public phone charges apply.

Online claiming same day deletion for Medicare patient claims

If you become aware that an error was made while entering or submitting a patient claim using the online claiming channel on the day it is transmitted and processed, the Medicare system will allow you to request the deletion of the claim using your desktop.

The 90-day cheque scheme

The 90-day cheque scheme was introduced in July 2001 to guarantee General Practitioners payment of the Medicare scheduled fee for patient claims. If a claimant does not present the cheque made in favour of the doctor to the practice within 90 days of its issue, Medicare Australia will cancel the cheque. The benefit will then be paid by EFT into the doctor's bank account. To take advantage of the scheme register by calling Medicare Australia on **1800 032 259**.

Intention to bulk bill

If a claimant is billed privately when the intention was to bulk bill, this can be corrected by:

- the practitioner informing the claimant in writing that the debt has been cancelled and asking the claimant to sign an assignment of benefit form
- sending the signed assignment of benefit form with a completed bulk bill claim form (DB1N or DB1H) to Medicare with a copy of the letter sent to the claimant.

These actions should take place as soon as possible after the service was rendered as the bulk billing system is not to be used to recover bad debts. All bulk bill claims should be lodged within six months of the service.

How the claimant receives the benefit

Claimants who pay for the service in full can elect to receive the rebate by cash, EFT to their bank or financial institution account, or by cheque. Claimants must give consent for a practitioner to lodge claims on their behalf. EFT payment should be made within three to six working days of lodgement.

If the consultation is not paid for, or the claimant pays only the gap, a cheque in favour of the practitioner will be sent to the claimant, who will need to forward it to the practitioner. The claimant must give consent for the practitioner to lodge the claim on their behalf. The cheque is issued within a minimum of 16 days from the date of lodgement. Cheques are not sent directly to the practitioner or practice.

Bulk billing

If a practitioner agrees to the bulk billing method, patients assign their right to a benefit to the practitioner as full payment for the medical service. The practitioner (or any other person or company) cannot make any additional charge for the service. This means that if the practitioner bulk bills, the patient cannot be charged a booking fee, an administration fee, a charge for bandages or record keeping, or a charge by the practitioner's service company. It is a legal requirement that the assignment of benefit form be signed by the patient only after the service has been provided and the form completed. A copy of the completed assignment form must be given to the patient.

Additional bulk billing incentives are available for General Practitioners who bulk bill Commonwealth concession patients and children under 16 years. To receive the payment, medical practitioners need to claim a Medicare Benefits Schedule item in addition to the relevant item for the professional service provided to the patient.

For more information visit the Medicare Australia web site or call **132 150***.

Submitting bulk bill claims electronically

Electronic claiming via the Internet (online claiming)

Online claiming enables practices to lodge bulk bill claims via the Internet.

General Practitioners, specialists, radiologists and diagnostic imaging houses can lodge bulk bill claims using the new system.

The advantages of sending bulk bill claims using online claiming are:

- more efficient payment via electronic funds transfer to the practitioner's financial institution account
- claims can be transmitted 24 hours a day, seven days a week
- fewer claim rejections and minimal operator intervention
- problems are resolved quickly with the help of prompt electronic exception statements
- faster payments because processing staff are no longer waiting on paper documentation to process claims
- online eligibility checking for bulk bill claims, leading to a lower rate of rejected claims and improved reconciliation for practices
- certainty the claim has been lodged
- the highest levels of confidentiality, privacy and authentication available for transmitting medical data through Public Key Infrastructure
- immediate confirmation of receipt of bulk bill claims—the data is transmitted directly to Medicare Australia rather than through a third party communication carrier
- paperless business with Medicare Australia—it reduces the need to send documentation to Medicare Australia.

There should also be a minimal need for practice staff to re-key information. The Medicare claiming function is integrated into the practice management system (PMS) and builds a claim from information already stored.

Online claiming software has been released to software vendors for integration into their practice management systems. Some suppliers already offer practices the new claiming facility. If you use a PMS please contact your software supplier to determine when they will be making online claiming available.

How online claiming impacts on Medclaims

The bulk bill component of online claiming is the replacement for the current Medclaims system, although Medclaims will continue to be available for the submission of bulk bill claims for some time. Practitioners who continue with Medclaims rather than adopt online claiming will receive the same level of support and assistance that is currently available.

* Local call rates. Normal mobile and public phone charges apply.

For more information, please contact the Medicare Australia eBusiness Service Centre on **1800 700 199**.

Medicare Easyclaim

From the second half of 2007, a new electronic claiming channel, Medicare Easyclaim, will be available. Medicare Easyclaim allows practices to lodge bulk bill claims using the existing EFTPOS terminals already in most practices.

The advantages of the new electronic claiming channel include:

- no batching or storing of claims—bulk bill claims lodged using Medicare Easyclaim will be entirely paperless
- your rebate is paid into your nominated bank account, usually on the next working day
- instant confirmation of a patient's concessional entitlement status.

For more information about Medicare Easyclaim visit the Medicare Australia web site.

Submitting bulk bill claims manually

A non-electronic bulk bill claim consists of:

- a claim form (DB1N, DB1N-AH or DB1H)
- a "batch" of assignment forms (DB2-GP, DB2-AH, DB2-OT, DB3, DB4 or DB5) which detail the services to patients.

Claims for in-hospital services must be batched separately from services provided outside hospital. Medicare Australia has scanning technology to process non-electronic bulk bill claims.

The scanning equipment uses image and optical character recognition techniques and DB2 forms have been designed to enable the equipment to read and interpret details of the claim. The forms can be used for all services except for pathology. Separate assignment vouchers are available for GPs (DB2-GP) and others (DB2-OT). Claims for scanning must be batched separately from other claims. The DB4 form (all practices except pathology) and DB5 form (pathology only) are continuous computer stationery versions of the claim form.

Submitting hard copy bulk bill claims for pathology

A bulk bill claim on Medicare for requested pathology consists of:

- a claim form (DB1N or DB1H) and a combined assignment of benefits/pathology request form (DB3 or DB5)
- a claim form (DB1N or DB1H), an assignment of benefits form (DB2-GP, DB2-OT, or DB4) and the pathology request.

Usually a patient can only assign benefits after a service has been provided. However, this is not possible in many instances of requested pathology services. For this reason, forms have been designed to enable patients to offer to assign benefits to the pathologist. If the pathologist accepts the offer to assign, the service details must be entered on the assignment form and the offer attached.

* Local call rates. Normal mobile and public phone charges apply.

Completing patient details on a bulk bill claim

Information on completing forms is included with each supply of forms.

Patient details on the assignment form need to be completed for bulk bill forms to be scanned. Either:

- imprint the patient's card using a Medicare imprinter to show the Medicare number. Complete the box marked "Card Ref. No." by writing the number appearing at the left of the patient's name on the Medicare card (if this is not completed, delays may be experienced in claiming benefits)
- where the card is not presented, complete the form by writing details of the Medicare number and card reference number (if known), first name, initial and surname of the patient treated.

The preferred method is to use the patient's current Medicare card as it ensures the details are complete and accurate, and this assists in efficient claims processing. It also confirms the patient's eligibility (the card should be checked for the date to which it is valid and to see if the person has restricted eligibility—for example, "Visitor RHCA").

Where a patient presenting without a Medicare card has agreed to be bulk billed and indicates that they have been issued with a card but do not know their Medicare card number, the practitioner may call the Medicare enquiry line on **132 150*** to obtain the patient's Medicare card number.

If a patient's Medicare number is not available, Medicare can still be bulk billed if the patient's name, date of birth and current address are included on the voucher. The claim may be delayed while additional checking is done. If eligibility cannot be confirmed, the service for the patient will be rejected.

Completing assignment of benefit

The person assigning benefit should complete the following sections on the bulk bill form:

- one of the assignment boxes
- patient's signature and date.

Where a patient is unable to sign, the patient's parent/guardian or other responsible person may complete the form. The responsible person must be somebody other than the practitioner, practitioner's staff, hospital proprietor, hospital staff, nursing home proprietor or nursing home staff. The reason the patient is unable to sign should also be stated.

In the absence of a responsible person, the patient's signature section should be left blank, and in the section headed "Practitioner's use" an explanation should be given as to why the patient was unable to sign (for example, "unconscious" or "injured hand"). This note should be signed or initialled by the practitioner. If, in the opinion of the practitioner, the reason is of such a sensitive nature that revealing it would constitute an unacceptable breach of patient confidentiality or cause embarrassment, the practitioner can give the reason as "due to medical condition". This reason should not be used routinely and in most cases it is expected that a more specific explanation will be given.

* Local call rates. Normal mobile and public phone charges apply.

Lodgement

All assignment of bulk bill benefit claims must be lodged within six months of the date of service, although an application can be made to the Minister for Health and Ageing or his delegate, on a special Medicare form, for an extension of the period if special circumstances exist. Special circumstances do not include collection of bad debts. All bulk bill claims should be mailed to Medicare (GPO Box 9822 in each capital city). Bulk bill claims may also be left at Medicare offices. Claims that have been electronically transmitted should be marked appropriately. A stamp is available for use with paperwork for electronically lodged claims, and is available by calling the provider enquiry line on **132 150***.

Payment of bulk bill claims

Payment is generally made via electronic funds transfer (EFT). Practitioners must provide their relevant bank account details. Where bank account details are incorrect or have not been supplied, a cheque will be sent to the practitioner together with a statement of benefit listing all services that have been paid. The statement will also show:

- a reason code for any rejected services
- where the benefit paid differs from the benefit claimed
- where a Medicare number has changed or was not present on the assignment form
- where a Medicare card is about to expire.

Payments for general and pathology bulk bill claims are dispatched in accordance with the Australian Government's minimum payment times. Minimum payment times are not guaranteed payment times, however most claims are paid in this period. Additional time should be added for mail handling. There is no maximum payment time set.

Medicare reason codes associated with the rejection of the claim are available via Medicare Australia's web site.

* Local call rates. Normal mobile and public phone charges apply.

Retaining bulk billing vouchers

The original bulk bill voucher for claims that have been sent electronically must be kept for two years. They can either be stored in hard copy at the practice or scanned and kept electronically. Medicare Australia can store them for doctors but the vouchers must be sent in at the time of claiming.

Assignment forms sent to Medicare Australia can be sent to GPO Box 9822 in each capital city. Medicare Australia will retain the Medicare copy of bulk bill claims that have been sent manually.

Rejection of claims

To process bulk bill claims quickly, all forms need to be completed properly. If there are discrepancies or omissions in the details appearing on the form, or there is some doubt regarding eligibility, claims may be delayed.

Claims will be rejected if:

- the assignment form has any major omissions such as date or description of service
- the claim form (DB1N, DB1N-AH or DB1H) has not been witnessed
- the claim form has not been signed by the practitioner

(For the above three rejections, the claim will be returned with an explanatory letter and a corrected claim can be resubmitted.)

- the patient is ineligible for benefit, for example, the service was provided after the benefit period had expired
- the benefit is not payable due to various rules and interpretations.

(For the above two rejections, the voucher will be retained by Medicare and an explanation will appear on the cheque statement. If the reason quoted is not understood please call the state provider liaison officer on **132 150***.)

Medicare reason codes associated with the rejection of claims can be found at Medicare Australia's web site at.

Stationery

Bulk bill stationery consists of the following forms:

- claim forms DB1N, DB1N-AH or DB1H
- assignment of benefit forms DB2-GP, DB2-AH, DB2-OT, DB3, DB4 and DB5
- DB6B to reorder stationery.

Approved forms

It is a legislative requirement that all claims made for a Medicare benefit must be submitted on an approved form. Approval to produce forms generated by practice software can be obtained from the Minister's delegate at Medicare Australia. Call **(02) 6124 6324** or email your request to **medicare.claims.policy@medicareaustralia.gov.au**

* Local call rates. Normal mobile and public phone charges apply.

Assignment of benefit forms

Assignment of benefit forms DB2-GP, DB2-AH, DB2-OT, DB3 and DB4 are printed in triplicate for use where the claim is not transmitted electronically. The original is sent to Medicare Australia in batches accompanied by a practitioner claim form (DB1N, DB1N-AH or DB1H).

A two-part assignment of benefit form DB4E is available for electronically transmitted claims.

The patient must receive a copy of the assignment form after the service, and a copy is held for the practitioner's records.

The DB5 is printed in duplicate. The original is sent to Medicare Australia in batches together with the offers to assign and a claim form DB1N or DB1H.

Enquiries about bulk bill claims

Claiming practitioners can call Medicare Australia on **132 150*** for information about their bulk bill claims.

Obtaining stationery, imprinters, plastic cards, brochures and posters

Stationery

Medicare stationery is available from Leigh-Mardon, the Medicare Australia printing contractor. Stationery can be obtained by completing a stationery reorder form (DB6B) and sending it to:

Leigh-Mardon
Fax: (02) 6230 0477

or by mail to:
Medicare Australia
Locked Bag 4444
Tuggeranong ACT 2901

Orders are usually dispatched within 48 hours. Please allow time for delivery.

Stationery reorder forms (DB6B) are available to download from Medicare Australia's web site.

Imprinters

Imprinters are available from Leigh-Mardon by calling **1800 067 307**.

Plastic cards

Plastic cards containing practice details for imprinting on stationery are available from Medicare Australia on request from the address above.

* Local call rates. Normal mobile and public phone charges apply.

Brochures and posters

Brochures and posters that inform patients about Medicare, the Pharmaceutical Benefits Scheme, the Australian Childhood Immunisation Register, the 30 per cent Private Health Insurance Rebate, the Australian Organ Donor Register, and various enrolment and claiming forms are available for practitioners' surgeries. If you would like to assist your patients by displaying all or some of these, please call **132 150***.

Forms

Form DB1N

The DB1N form is used for submitting bulk bill claims for out of hospital services.

DETAILS OF SERVICE PROVIDER

NAME

ADDRESS

SERVICE PROVIDER / REGISTRATION NUMBER

DECLARATION BY PRACTITIONER OR OPTOMETRIST WHO RENDERED THE SERVICES

I claim Medicare benefits, being the services 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 above assignment forms or claims transmission summary sheet, to the Practitioner specified below or to from whom Medicare has rendered the services and rendered;

IMPORTANT: Only complete this section if the payment is to be made to a provider other than the service provider.

* Print name of Practitioner

Payee's Provider Number

Signature of Practitioner who rendered the services

Signature of Witness to above signature

Printed name of Witness

Date

Designated G030

Medicare 44 CLAIM FOR ASSIGNED BENEFIT FOR SERVICES RENDERED TO NON-HOSPITAL PATIENT. This form also applies to a practitioner who renders DB1N or DB1N-AH services under section 20A of the Health Insurance Act 1973.

DB1N

DATE OF CLAIM DD / MM / YY

CLAIM NUMBER

NUMBER OF ASSIGNMENT FORMS

TOTAL BENEFIT AMOUNT CLAIMED \$

HOLD BOTH ENDS FIRMLY - PULL TO SEPARATE PRACTITIONER COPY

• 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 professional services specified in the attached assignment forms or claims transmission summary sheet.
 • None of the amounts claimed is in respect of a service -
 (a) that was rendered to an in-patient of a hospital or approved day hospital facility;
 (b) 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);
 (c) 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
 (d) which is precluded from Medicare benefit by any provision of the Health Insurance Act 1973.

Form DB1N

Form DB1N-AH

The DB1N-AH form is used by allied health professionals for out of hospital services.

DETAILS OF SERVICE ALLIED HEALTH PROFESSIONAL

NAME

ADDRESS

SERVICE PROVIDER / REGISTRATION NUMBER

DECLARATION BY ALLIED HEALTH PROFESSIONAL WHO RENDERED THE SERVICES

I claim Medicare benefits, being the services 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 or from whom Medicare has rendered the services and 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 / REGISTRATION NUMBER

Signature of Allied Health Professional who rendered the services

Signature of Witness to above signature

Printed name of Witness

Date

Designated 06/04

Medicare 33 CLAIM FOR ASSIGNED BENEFIT FOR SERVICES RENDERED TO NON-HOSPITAL PATIENT. This form also applies to a practitioner who renders DB1N or DB1N-AH services under section 20A of the Health Insurance Act 1973.

DB1N-AH

DATE OF CLAIM DD / MM / YY

CLAIM NUMBER

NUMBER OF ASSIGNMENT FORMS

TOTAL BENEFIT AMOUNT CLAIMED \$

HOLD BOTH ENDS FIRMLY - PULL TO SEPARATE PRACTITIONER COPY

• 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 or claims transmission summary sheet.
 • None of the amounts claimed is in respect of a service -
 (a) that was rendered to an in-patient of a hospital or approved day hospital facility;
 (b) 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);
 (c) 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
 (d) which is precluded from Medicare benefit by any provision of the Health Insurance Act 1973.

Form DB1N-AH

Form DB1H

The DB1H form is used for submitting bulk bill claims for in-hospital services.

DETAILS OF SERVICE PROVIDED - PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN -

Medicare 44 ASSIGNMENT FORM DB1H

DATE OF CLAIM DO / MM / YY CLAIM NUMBER #

NUMBER OF ASSIGNMENT FORMS TOTAL BENEFIT AMOUNT CLAIMED \$

SIGNATURE OF PRACTITIONER WHO RENDERED THE SERVICES

SIGNATURE OF WITNESS TO ABOVE SIGNATURE

PRINTED NAME OF WITNESS DATE

DESIGNED 03/06

HOLD BOTH FORMS PRIVATE - MAIL TO SEPARATE PRACTITIONER COPY

Form DB1H

Note: The only difference between the DB1N, DB1N-AH and DB1H forms is that DB1H is used when submitting bulk bill claims for in-hospital patients and the DB1N and DB1N-AH is for non-hospital patients. Vouchers for in-hospital and non-hospital services cannot be mixed in one claim.

Form DB2-AH

The DB2-AH form is used by allied health professionals. This form can only be used in conjunction with the DB1N-AH.

PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN -

Medicare 38 ASSIGNMENT FORM DB2-AH

PATIENT REF. No. DATE OF SERVICE DO / MM / YY

S/D DESCRIPTION OF SERVICE ITEM NO. BENEFIT ASSIGNED

METHOD OF REFERRAL (MVA) REFERRAL OR REQUEST DATE (DD/M/YY)

REFERRING GP/ REQUESTING PRACTITIONER PROVIDER REGISTRATION No.

NAME & ADDRESS OF REQUESTING/REFERRING PRACTITIONER

NAME & PROVIDER REGISTRATION No. OR ADDRESS OF ALLIED HEALTH PROFESSIONAL WHO RENDERED THE ABOVE SERVICE(S) PROFESSIONAL USE

SIGNATURE OF PATIENT DATE

DESIGNED 03/06

PRACTITIONER COPY

Form DB2-AH

Form DB2-GP

The DB2-GP form has been specifically designed for GPs.

PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN -

Medicare 81 ASSIGNMENT FORM DB2-GP

PATIENT REF. No. DATE OF SERVICE DO / MM / YY

DESCRIPTION OF SERVICE ITEM NO. X BENEFIT ASSIGNED

CONSULTATION LEVEL A 3 X

CONSULTATION LEVEL B 23 X

CONSULTATION LEVEL C 36 X

STANDARD CONSULTATION 53 X

NAME & PROVIDER No. OR ADDRESS OF PRACTITIONER WHO RENDERED THE ABOVE SERVICE(S) No. OF PATIENTS ATTENDED

SIGNATURE OF PATIENT DATE

DESIGNED 03/06

PRACTITIONER COPY

Form DB2-GP

Form DB2-OT

The DB2-OT form is used by practitioners other than GPs.

PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN

Medicare 98 ASSIGNMENT FORM DB2-OT

PATIENT REF No. FIRST NAME INITIAL SURNAME
 DATE OF BIRTH
 RESIDENTIAL ADDRESS
 EXPIRY DATE CHECKED

Medicare NUMBER IF INPRINTER NOT USED
 LSPH (Required for diagnostic imaging (ultrasound and/or x-rays) only)

DESCRIPTION OF REQUESTED PATHOLOGY
 I assign my right to benefits to the practitioner who has rendered the services, or in the case of requested pathology, the approved pathology practitioner who will render the requested pathology service(s).

SIGNATURE OF PATIENT DATE

NAME & PROVIDER No. OR ADDRESS OF PRACTITIONER WHO RENDERED THE ABOVE SERVICE(S)
 PRACTITIONER USE

DESIGNED 03/06

Form DB2-OT

Form DB3

The DB3 form is designed to be used by pathologists to claim pathology services.

The form can also be used as an offer to assign form. It must contain all patient and service details. Unlike the DB2-OT and DB2-GP forms, multiple dates of service can be shown.

Medicare FOR PATHOLOGY DB3 SERVICES ONLY

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 DATE

OR I OFFER TO ASSIGN FORM No. _____ IS ATTACHED

PRECEDENCE NOTE: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of Medicare benefit programs and may be used to verify medical records. Its collection is authorized by provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health and Family, Department of Human Services, Centlink, other relevant agencies or to a person in the medical profession associated with this claim or an authorized agent of any of them.

DESCRIPTION CODE	DATE	DATE	MONTH	YEAR	SD	ITEM NUMBER	BENEFIT ASSIGNED

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

PATIENT COPY DESIGNED 03/06

Form DB3

Form DB4

The DB4 form is a continuous stationery version of DB2s designed for office accounting machines. Its use is the same as for DB2 forms.

Medicare ASSIGNMENT FORM No.

TO BE COMPLETED BY THE PERSON ASSIGNING BENEFITS TO THE PRACTITIONER WHO RENDERED 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 DATE

PRECEDENCE NOTE: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of Medicare benefit programs and may be used to verify medical records. Its collection is authorized by provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health and Family, Department of Human Services, Centlink, other relevant agencies or to a person in the medical profession associated with this claim or an authorized agent of any of them.

DESCRIPTION CODE	DATE	DATE	MONTH	YEAR	SD	ITEM NUMBER	BENEFIT ASSIGNED

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

Form DB4

