

- If completing by hand please use BLACK PEN -

P  
A  
T  
I  
E  
N  
T  
  
D  
E  
T  
A  
I  
L  
S

FIRST NAME ..... INITIAL .....  
SURNAME .....  
RESIDENTIAL ADDRESS .....  
DATE OF BIRTH DD / MM / YYYY ..... EXPIRY DATE CHECKED X  
MEDICARE NUMBER .....  
PRACTITIONER USE  
PATIENT UNABLE TO SIGN ☐

medicare

81

ASSIGNMENT  
FORM

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

DB2-GP

PATIENT  
REF. No. ☐

DATE OF SERVICE  
DD / 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	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

I assign my right to benefits to the practitioner who has rendered the service(s).



SIGNATURE OF PATIENT

DATE

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

No. OF  
PATIENTS  
ATTENDED

☐ ☐

DB2-GP(a).1208

811

Medicare copy



- If completing by hand please use BLACK PEN -

P  
A  
T  
I  
E  
N  
T  
  
D  
E  
T  
A  
I  
L  
S

FIRST NAME ..... INITIAL .....  
SURNAME .....  
RESIDENTIAL ADDRESS .....  
DATE OF BIRTH DD / MM / YYYY ..... EXPIRY DATE CHECKED X  
MEDICARE NUMBER .....  
PRACTITIONER USE  
PATIENT UNABLE TO SIGN ☐

medicare

81

ASSIGNMENT  
FORM

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

DB2-GP

PATIENT  
REF. No. ☐

DATE OF SERVICE  
DD / 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	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

I assign my right to benefits to the practitioner who has rendered the service(s).



**Privacy and your personal information**

Your personal information is protected by law, including the *Privacy Act 1988*, and is collected for a Social Security, Family Assistance, Medicare, Child Support and CRS purpose, depending on the service or payment concerned. This information may be required by law or collected voluntarily when you apply for services or payments. Your information is used for the assessment and administration of payments and services and may also be used within Human Services, or disclosed to other parties or agencies, where you have provided consent or it is required or authorised by law.  
Visit [humanservices.gov.au/privacy](http://humanservices.gov.au/privacy) or your local Service Centre for more information.

DB2-GP(a).1208

811

Patient copy



- If completing by hand please use BLACK PEN -

P  
A  
T  
I  
E  
N  
T  
  
D  
E  
T  
A  
I  
L  
S

FIRST NAME ..... INITIAL .....  
SURNAME .....  
RESIDENTIAL ADDRESS .....  
DATE OF BIRTH DD / MM / YYYY ..... EXPIRY DATE CHECKED X  
MEDICARE NUMBER .....  
PRACTITIONER USE  
PATIENT UNABLE TO SIGN ☐

medicare

81

ASSIGNMENT  
FORM

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

DB2-GP

PATIENT  
REF. No. ☐

DATE OF SERVICE  
DD / 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	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

I assign my right to benefits to the practitioner who has rendered the service(s).

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

No. OF  
PATIENTS  
ATTENDED

☐ ☐

DB2-GP(a).1208

811

Practitioner copy

