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medicare 81 **ASSIGNMENT FORM** (This form is the approved form as prescribed under section 20A of the *Health Insurance Act 1973*) DB2-GP

PATIENT DETAILS

FIRST NAME Firstname INITIAL Initial

SURNAME Surname

RESIDENTIAL ADDRESS Add1

Add2

DATE OF BIRTH DD / MM / YYYY DOB

EXPIRY DATE CHECKED X

MEDICARE NUMBER MA MA MA MA MA MA MA MA MA MA

PRACTITIONER USE PATIENT UNABLE TO SIGN ☐

PATIENT REF. No. Ref

DATE OF SERVICE DD / MM / YY DD DD MM MM YY YY

DESCRIPTION OF SERVICE	ITEM NO.	X	BENEFIT ASSIGNED
CONSULTATION: LEVEL A	3	X	Ben1
CONSULTATION: LEVEL B	23	X	Ben2
CONSULTATION: LEVEL C	36	X	Ben3
STANDARD CONSULTATION	53	X	Ben4
Des5	m1 m1 m1 m1 m1		n5 n5 n5 . n5 n5
Des6	m2 m2 m2 m2 m2		n6 n6 n6 . n6 n6

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)
Provider

No. OF PATIENTS ATTENDED 0 1

DB2-GP(a).1208

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CONSULTATION: LEVEL C	36	X	Ben3
STANDARD CONSULTATION	53	X	Ben4
Des5	m1 m1 m1 m1 m1		n5 n5 n5 . n5 n5
Des6	m2 m2 m2 m2 m2		n6 n6 n6 . n6 n6

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/ /

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

No. OF PATIENTS ATTENDED 0 1

DB2-GP(a).1208

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Patient copy

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PATIENT DETAILS

FIRST NAME Firstname INITIAL Initial

SURNAME Surname

RESIDENTIAL ADDRESS Add1

Add2

DATE OF BIRTH DD / MM / YYYY DOB

EXPIRY DATE CHECKED X

MEDICARE NUMBER MA MA MA MA MA MA MA MA MA MA

PRACTITIONER USE PATIENT UNABLE TO SIGN ☐

PATIENT REF. No. Ref

DATE OF SERVICE DD / MM / YY DD DD MM MM YY YY

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Des5	m1 m1 m1 m1 m1		n5 n5 n5 . n5 n5
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/ /

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

No. OF PATIENTS ATTENDED 0 1

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