

## Treatment Service Voucher for use by General Practitioners only

 Each service voucher must be used only for services rendered to one patient, at the one attendance

- 1 Complete the Patient Details section by writing the patient's file number, first name, initial and surname. *If the file number is not known*, include date of birth and address.
- 2 If the service is one of the pre-printed services place an X as indicated on the form.
- 3 If the service is not one of the pre-printed services write the Item Number or Description of Service in the space provided.
- 4 The 'Condition Treated' section should only be completed if the veteran holds a White card for specific conditions, or if the service is an emergency.
- 5 If the service is provided in a hospital, specify the hospital in the space provided.
- 6 If treatment is provided in a location other than Rooms, please specify.
- 7 If pathology is requested, provide a brief description.
- 8 Ensure the patient provides the information requested and signs the form. If the patient is unable to sign, please sign the appropriate section.
- 9 For emergency services, cross and sign the appropriate section.
- 10 Submit the Departmental copy and any relevant documents with your claim, and ensure the patient receives the Patient copy. Retain the Claimant copy for your records.

PRIVACY NOTE: The information sought on this form is to enable service verification and claim processing. This information will be disclosed to Medicare Australia to process the payment.

Continued on next page

10.1	General Practitioner	realment Se	vice vol	ucitet
ULL AME	Date of Service DD / MM / YY			
ATE OF BIRTH / /	DESCRIPTION OF SERVICE	ITEM NO.	Х	AMOUNT CLAIMED
DDRESS	Consultation Level B	23	Х	•
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				<del>                                     </del>
File number				<del>                                     </del>
Description of requested				<del>                                     </del>
pathology				
I certify that I have received the services described on this voucher, or, the Practitioner has requested Pathology tests for me. I am not entitled to claim third party or worker's compensation for these services.	Number of kilometres travelled  Name of Hospital or Residential Aged Care Facility and/or facility ID			
Patient's Signature	Treatment location Posidential Aged			
Or I certify – The patient is unable to sign The service is associated with an emergency	Treatment location (if other than rooms) Visit Hospital Residential Aged Care Facility			
	Condition treated (White card holders and emergencies only	<i>(</i> )		
Provider's Signature	Name of Practitioner who	,		Practitioner use
1216G (08/10) – ORIGINAL – Department copy	rendered the services			
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	Australian Government Department of Veterans'			
PLEASE COMPLETE THIS FORM ONLINE AND THEN PRINT TO SIGN	•		,	
ULL	General Practitioner	reatment Se	rvice voi	ıcner
AME	Date of Service DD / MM / YY		/	
ATE OF BIRTH / /	DESCRIPTION OF SERVICE	ITEM NO.	Х	AMOUNT CLAIMED
DDRESS	Consultation Level B	23	Х	<u> </u>
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File number				<del>                                     </del>
Description of requested				<del>                                     </del>
pathology				
certify that I have received the services described on this voucher, or, the Practitioner has requested Pathology tests for me. I am not entitled to claim third party or worker's	Number of kilometres travelled		Numbe	r of Patients attended
compensation for these services.	Name of Hospital or Residential Aged Care Facility and/or facility ID			
Patient's Signature			1 0 11	C.1.A
Or I certify – The patient is unable to sign The service is associated with an emergency	Treatment location (if other than rooms)	Hospital	Care Fa	ntial Aged acility
	Condition treated (White card holders and emergencies only)			
Provider's Signature	Name of Practitioner who	7		Practitioner use
Provider's Signature	rendered the services			
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	Australian Government Department of Veterans'			
PLEASE COMPLETE THIS FORM ONLINE AND THEN PRINT TO SIGN				
	General Practitioner	reatment Se	rvice Vol	ucher
JLL AME	Date of Service DD / MM / YY			
ATE OF BIRTH / /	DESCRIPTION OF SERVICE	ITEM NO.	Х	AMOUNT CLAIMED
DDRESS	Consultation Level B	23	X	•
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File number				V V V
Description of requested pathology				
Description of requested pathology  certify that I have received the services described on this voucher, or, the Practitioner	Number of		Numbe	or of Patients attended
Description of requested pathology  certify that I have received the services described on this voucher, or, the Practitioner has requested Pathology tests for me. I am not entitled to claim third party or worker's	Number of kilometres travelled Name of Hospital or Residenti	al Aged Care Facil		
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Description of requested pathology  certify that I have received the services described on this voucher, or, the Practitioner has requested Pathology tests for me. I am not entitled to claim third party or worker's compensation for these services.  Patient's Signature	Name of Hospital or Residenti  Treatment location Visit	al Aged Care Facil	ity and/or fac	ility ID
Description of requested bathology  certify that I have received the services described on this voucher, or, the Practitioner has requested Pathology tests for me. I am not entitled to claim third party or worker's compensation for these services.  Patient's Signature  The patient is	kilometres travelled  Name of Hospital or Residenti  Treatment location (if other than rooms)  Condition treated (White card	Hospital	ity and/or fac	ility ID
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