

- If completing by hand please use BLACK PEN -

PATIENT DETAILS

FIRST NAME INITIAL

SURNAME

RESIDENTIAL ADDRESS

DATE OF BIRTH DD / MM / YYYY EXPIRY DATE CHECKED X

MEDICARE NUMBER

LSPN

Required for diagnostic imaging/ radiation oncology services only

DESCRIPTION OF REQUESTED PATHOLOGY

medicare **98** **ASSIGNMENT FORM** (This form is the approved form as prescribed under section 20A of the Health Insurance Act 1973) **DB2-OT**

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

S/D	DESCRIPTION OF SERVICE	ITEM NO.	BENEFIT ASSIGNED

PERIOD OF REFERRAL IN MONTHS (MM) REFERRAL OR REQUEST DATE (DD/MM/YY)

CROSS IF INDEFINITE X REFERRING OR REQUESTING PRACTITIONER PROVIDER No.

NAME & ADDRESS OF REQUESTING/REFERRING PRACTITIONER

I assign my right to benefits to the practitioner who has rendered the service(s), 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 PATIENT UNABLE TO SIGN ☐

DB2-OT(a).1208

981

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