



**IN-PATIENT SERVICE - BILLING DETAILS**  
**FOR SERVICES PROVIDED BY SURGEONS OR ASSISTANT SURGEONS**

**Doctor Claim**  
**PO Box 6267, Kincumber NSW 2251**  
**Phone: 1300 760 802 Fax: 1300 760 803**  
**Email: [accounts@doctorclaim.com.au](mailto:accounts@doctorclaim.com.au)**  
**Website: [www.doctorclaim.com.au](http://www.doctorclaim.com.au)**

|  |  |                                     |  |
|--|--|-------------------------------------|--|
| Type of claim - Please Tick                | No Gap: <input type="checkbox"/>                     | Known Gap: <input type="checkbox"/> | Account to the Patient: <input type="checkbox"/> |
| Doctor Name:                               |  | Dr Provider Number:                 | Name of Hospital:                                |
| Surgeon Services: <input type="checkbox"/> | Assistant Surgeon Services: <input type="checkbox"/> | If Applicable, DVA file No.:        | If Applicable, WorkCover Claim No.:              |

|                                       |                        |  |  |  |                 |
|---------------------------------------|------------------------|--|--|--|-----------------|
| Patient Health Fund & Membership No.: |                        | Medicare Card No. & Patient Reference No.: |  |  |                 |
| <b>Patient details</b>                | <b>Date of Service</b> | <b>CMBS Item Number</b>                    | <b>Fee for Each CMBS item (where gap exists)</b> | <b>Referring Doctor Details OR Primary Surgeon Details</b> | <b>Comments</b> |
| Insert Patient's sticker here:        |                        |  |  |  |                 |
|                                       |                        |  |  |  |                 |
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**Assistant Surgeon Service** - Please provide applicable surgical CMBS item(s) performed by the surgeon:

Applicable Service Conditions - Tick the box below where applicable:

|  |  |
|--|--|
| Referred within a hospital <input type="checkbox"/>      | Deemed "not normal aftercare" <input type="checkbox"/> |
| Considered "not for comparison" <input type="checkbox"/> | Self determined <input type="checkbox"/>               |
| Part of multiple procedure <input type="checkbox"/>      | Performed on separate sites, Please specify:           |

|  |  |                                     |  |
|--|--|-------------------------------------|--|
| Type of claim - Please Tick                | No Gap: <input type="checkbox"/>                     | Known Gap: <input type="checkbox"/> | Account to the Patient: <input type="checkbox"/> |
| Doctor Name:                               |  | Dr Provider Number:                 | Name of Hospital:                                |
| Surgeon Services: <input type="checkbox"/> | Assistant Surgeon Services: <input type="checkbox"/> | If Applicable, DVA file No.:        | If Applicable, WorkCover Claim No.:              |

|                                       |                        |  |  |  |                 |
|---------------------------------------|------------------------|--|--|--|-----------------|
| Patient Health Fund & Membership No.: |                        | Medicare Card No. & Patient Reference No.: |  |  |                 |
| <b>Patient details</b>                | <b>Date of Service</b> | <b>CMBS Item Number</b>                    | <b>Fee for Each CMBS item (where gap exists)</b> | <b>Referring Doctor Details OR Primary Surgeon Details</b> | <b>Comments</b> |
| Insert Patients sticker here:         |                        |  |  |  |                 |
|                                       |                        |  |  |  |                 |
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**Assistant Surgeon Service** - Please provide applicable surgical CMBS item performed by the surgeon:

Applicable Service Conditions - Tick the box below where applicable:

|  |   |
|--|---|
| Referred within a hospital <input type="checkbox"/>      | Deemed "not normal aftercare " <input type="checkbox"/> |
| Considered "not for comparison" <input type="checkbox"/> | Self Determined <input type="checkbox"/>                |
| Part of multiple procedure <input type="checkbox"/>      | Performed on separate sites, Please specify:            |

**Please Note**

- Please ensure that all your patient's billing details are provided: Patient's full name, date of birth, Medicare card and patient reference number, health fund and membership number.  
Otherwise advise UI (uninsured) or WC (WorkCover as applicable)
- If the patient is under 12 years of age, please provide the details of the primary caregiver (full name, date of birth, Medicare number and Health Fund details)
- Informed Financial Consent not required for No Gap Claims. However, it is recommended when issuing Known Gap and Patient Accounts.