



**IN-PATIENT SERVICE - BILLING DETAILS
FOR SERVICES PROVIDED BY ANAESTHETIST**

Doctor Claim
PO Box 6267, Kincumber NSW 2251
Phone: 1300 760 802 Fax: 1300 760 803
Email: accounts@doctorclaim.com.au
Website: www.doctorclaim.com.au

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|--|--|--|--|
| 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: |
| Anaesthetist Service: <input type="checkbox"/> | Assistant Anaesthetist Service: <input type="checkbox"/> | If Applicable, DVA file No.: | If Applicable, WorkCover Claim No.: |
| Patient Health Fund & Membership No.: | | Medicare Card No. & Patient Reference No.: | |

| Patient details | Date of Service | Start & Finish Times | CMBS Item Number | Fee for Each CMBS item (where gap exists) | Comments |
|--------------------------------|-----------------|----------------------|------------------|---|----------|
| Insert Patient's sticker here: | | | | | |
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Referring Doctor Details:

MODIFIERS - Please tick the box below where applicable:

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| ASA 3 <input type="checkbox"/> | ASA 4 <input type="checkbox"/> | ASA 5 <input type="checkbox"/> | Age (<1 or >70) <input type="checkbox"/> |
|--------------------------------|--------------------------------|--------------------------------|--|

Emergency In Hours: _____ Emergency After Hours: _____

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|---|--|--|--|
| 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: |
| Anaesthetist Service <input type="checkbox"/> | Assistant Anaesthetist Service: <input type="checkbox"/> | If Applicable, DVA file No.: | If Applicable, WorkCover Claim No.: |
| Patient Health Fund & Membership No.: | | Medicare Card No. & Patient Reference No.: | |

| Patient details | Date of Service | Start & Finish Times | CMBS Item Number | Fee for Each CMBS item (where gap exists) | Comments |
|-------------------------------|-----------------|----------------------|------------------|---|----------|
| Insert Patients sticker here: | | | | | |
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|--------------------------------|--------------------------------|--------------------------------|--|

Emergency In Hours: _____ Emergency After Hours: _____

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.