AUSTRALIAN MEDICAL BILLING SERVICE

PATIENT DETAILS FOR BILLING SERVICES

PRINCIPAL ANAESTHETIST ☐ ASSISTANT ANAESTHETIST ☐

Form return:
P.O. Box 5052 Mordialloc VIC 3195
Fax: 03 9587 9634
Email: lyn@ausmbs.com.au

Doctor _____ Provider Number _____ Hospital _____

Please Attach Patient Sticker

Type Of Claim

No Gap ☐
Known Gap ☐
Account to Patient ☐

Please Attach Patient Sticker

Type Of Claim

No Gap ☐
Known Gap ☐
Account to Patient ☐

Name of Surgeon or Principal Anaesthetist

Referring Doctor Provider Number

Date of Service

Name of Surgeon or Principal Anaesthetist

Referring Doctor Provider Number

Date of Service

Please only fill in the following details if the information is NOT on the Patient Sticker/ Bradma:

Medicare Number Ref No.

Health Fund Member No.

DVA No. TAC No.

WorkCover Claim No.

Please only fill in the following details if the information is NOT on the Patient Sticker/ Bradma:

Medicare Number Ref No.

Health Fund Member No.

DVA No. TAC No.

WorkCover Claim No.

CMBS Item Number	Comments
	Start Time:
	End Time:

GAP AMOUNT: $

CMBS Item Number	Comments
	Start Time:
	End Time:

GAP AMOUNT: $