AUSTRALIAN MEDICAL
BILLING SERVICE

PATIENT DETAILS FOR BILLING SERVICES

Form return:
P.O. Box 5052 Mordialloc, 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 ☐

Name of Referring Doctor

Referring Doctor Provider Number

Date of Referral 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 Veteran's Number

TAC Claim Number or Date of Accident

WorkCover Claim No. Employer

Please Attach
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CMBS Item Number	Comments	Fee for Each CMBS Item (where gap exists)

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Please Note:

1. Please ensure that all your patient's billing details are provided, including Patient's full Name, Date of Birth, Medicare card number, and patient reference number, health fund and membership number. Otherwise, please advise uninsured (U.I.), or WorkCover (W.C.)
2. If the patient is under 12 years of age, please provide the details of the primary caregiver including full Name, D.O.B, Medicare number and reference number, and Health fund and membership number.
3. Informed Financial Consent is not required for No-Gap payments, but is necessary for Known Gap, and patient accounts