



CLAIM FORM FOR SINGLE SERVICE EPISODES



MANATŪ HAUORA

DETAILS OF AUTHORISED PRACTITIONER

PRACTITIONER ID TYPE Medical Council of New Zealand Nursing Council of New Zealand/Midwifery Council of New Zealand

REGISTRATION NUMBER (i.e. MCNZ, NCNZ) AGREEMENT NUMBER - PAYEE NUMBER

DETAILS OF SERVICE AND CLAIM

NHI	EDD	LMP (est. if necessary)	Date of Service	Pregnancy Care (Code Required)	Urgent Out of Hours Pregnancy Care (Code Required)	Assessment Prior to TOP	Threatened Miscarriage	Miscarriage Services	Exceptional Circumstances (Code Required)	Postnatal Consultation by non-LMC		Amount Claimed
										Mother (M) Baby (B)	Date of Birth of Baby	
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Codes for Pregnancy/Urgent out of hours Pregnancy Care

- 1st Trimester
- 2nd/3rd Trimester - Unregistered Woman
- 2nd/3rd Trimester - Woman Away from Usual Place of Residence
- 2nd/3rd Trimester - Medical Emergency, LMC Contact Attempted, supporting documentation attached
- Following a Miscarriage/Termination of Pregnancy

Codes for Exceptional Circumstances

- Transfer to Secondary Maternity 48 hours prior to Established Labour
- Urgent non-LMC Assistance to Rural LMC
- Ambulance Transfer

TOTAL AMOUNT CLAIMED (GST inclusive) \$

CERTIFICATION

I certify that I have provided the above services in accordance with the service specifications in the Section 88 Maternity Service Notice and that the above information is correct.

Name of Authorised Practitioner (Capital letters)

Signature of Authorised Practitioner

Date

DETAILS OF REFERRALS

NHI	EDD	Date of Referral	Name of Practitioner or Secondary Maternity Service referred to	Specialist Type (e.g. Radiologist)	Reason for Referral (Use Referral Guidelines)
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Send completed form to: HealthPAC, Health Payments, Agreements and Compliance, P.O. Box 1026, WELLINGTON

Re-Order No. 59253
01/04



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