CLAIM FORM FOR SPECIALIST CONSULTATIONS (Obstetricians, Anaesthetists, Paediatricians)

MANATŪ HAUORA

DETAILS OF AUTHORISED PRACTITIONER

PRACTITIONER ID TYPE ☐ Medical Council of New Zealand

REGISTRATION NUMBER ☐☐☐☐☐☐ (i.e. MCNZ)

AGREEMENT NUMBER ☐☐☐☐☐☐–☐☐ PAYEE NUMBER ☐☐☐☐☐☐

OBSTETRICIAN ☐ ANAESTHETIST ☐ PAEDIATRICIAN ☐

DETAILS OF WOMAN

NHI ☐☐☐☐☐☐☐ EDD ☐☐/☐☐/☐☐☐☐

DETAILS OF BABY

NHI ☐☐☐☐☐☐☐ DATE OF BIRTH ☐☐/☐☐/☐☐☐☐

DETAILS OF REFERRAL

REFERRING LMC PRACTITIONER ID TYPE ☐ Medical Council of New Zealand ☐ Nursing Council of New Zealand/Midwifery Council of New Zealand

REFERRING LMC REGISTRATION NUMBER ☐☐☐☐☐☐ (i.e. MCNZ, NCNZ)

NAME OF REFERRING LMC

DETAILS OF SERVICE AND CLAIM

Date of Referral	Date of Service	Principal Reason for Referral (Use Referral Guidelines)	First Consultation (Obstetrician & Paediatrician only)	Subsequent Consultation (Obstetrician & Paediatrician only)	Anaesthetist Services	Specialist Obstetrician - Effecting Birth	Paediatrician Attendance at delivery	Amount Claimed
☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	☐☐☐☐	☐	☐	☐	☐	☐	$ ☐☐☐:☐☐
☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	☐☐☐☐	☐	☐	☐	☐	☐	$ ☐☐☐:☐☐
☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	☐☐☐☐	☐	☐	☐	☐	☐	$ ☐☐☐:☐☐
☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	☐☐☐☐	☐	☐	☐	☐	☐	$ ☐☐☐:☐☐

TOTAL AMOUNT CLAIMED (GST inclusive) $ ☐☐☐☐:☐☐

CERTIFICATION

I certify that I have provided the above services in accordance with the service specifications to the Section 88 Maternity Service Notice and that the above information is correct. I understand that the information will also be used to monitor the quality of patient care, treatment and health statistics in a manner consistent with the Health Information Privacy Code 1994.

Name of Authorised Practitioner (please print in capital letters)

Signature of Authorised Practitioner

Date

Send completed form to: **HealthPAC, Health Payments, Agreements and Compliance, P.O. Box 1026, WELLINGTON**

Re-Order No. 59256
01/04

CLAIM FORM FOR SPECIALIST CONSULTATIONS (Obstetricians, Anaesthetists, Paediatricians)

DETAILS OF AUTHORISED PRACTITIONER

PRACTITIONER ID TYPE ☐ Medical Council of New Zealand

REGISTRATION NUMBER ☐☐☐☐☐☐ (i.e. MCNZ)

AGREEMENT NUMBER ☐☐☐☐☐☐–☐☐ **PAYEE NUMBER** ☐☐☐☐☐☐

OBSTETRICIAN ☐ **ANAESTHETIST** ☐ **PAEDIATRICIAN** ☐

DETAILS OF WOMAN

NHI ☐☐☐☐☐☐☐ **EDD** ☐☐/☐☐/☐☐☐☐

DETAILS OF BABY

NHI ☐☐☐☐☐☐☐ **DATE OF BIRTH** ☐☐/☐☐/☐☐☐☐

DETAILS OF REFERRAL

REFERRING LMC PRACTITIONER ID TYPE ☐ Medical Council of New Zealand ☐ Nursing Council of New Zealand/Midwifery Council of New Zealand

REFERRING LMC REGISTRATION NUMBER ☐☐☐☐☐☐ (i.e. MCNZ, NCNZ)

NAME OF REFERRING LMC

DETAILS OF SERVICE AND CLAIM

Date of Referral	Date of Service	Principal Reason for Referral (Use Referral Guidelines)	First Consultation (Obstetrician & Paediatrician only)	Subsequent Consultation (Obstetrician & Paediatrician only)	Anaesthetist Services	Specialist Obstetrician - Effecting Birth	Paediatrician Attendance at delivery	Amount Claimed
/ /	/ /							$:
/ /	/ /							$:
/ /	/ /							$:
/ /	/ /							$:

TOTAL AMOUNT CLAIMED (GST inclusive) $ ☐☐☐☐:☐☐

CERTIFICATION

I certify that I have provided the above services in accordance with the service specifications to the Section 88 Maternity Service Notice and that the above information is correct. I understand that the information will also be used to monitor the quality of patient care, treatment and health statistics in a manner consistent with the Health Information Privacy Code 1994.

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