

CLAIM FORM FOR ULTRASOUND CONSULTATION



DETAILS OF AUTHORISED PRACTITIONER

PRACTITIONER ID TYPE Medical Council of New Zealand

REGISTRATION NUMBER (i.e. MCNZ)

AGREEMENT NUMBER - **PAYEE NUMBER**

DETAILS OF WOMAN/BABY

NHI **EDD** / / (not applicable for baby)

LMP / / Estimate if necessary (not applicable for baby)

SCAN FOR Mother Baby (not foetus)

DETAILS OF REFERRAL

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

REFERRING PRACTITIONER REGISTRATION NUMBER (i.e. MCNZ, NCNZ)

PRINCIPAL REASON FOR REFERRAL (use Ultrasound Indications List e.g. MF3)

DATE OF REFERRAL / /

SECOND/THIRD TRIMESTER ONLY

NAME OF LEAD MATERNITY CARER

NON-LMC REFERRAL AND EMERGENCY CIRCUMSTANCES Yes No
(If yes, supporting documentation required)

DETAILS OF SERVICE AND CLAIM

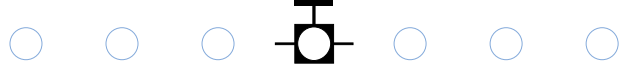
DATE OF SCAN / / **TOTAL AMOUNT CLAIMED** (GST inclusive) \$:

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. The scan has been performed as a result of a referral from the Authorised Practitioner identified in the details of the referral above. 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



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