MINISTRY OF HEALTH
MANATŪ HAUORA

General Medical Services Claim Schedule Form

Claim Summary Details

Claim Reference No. | Name Of Claimant | PAYEE No.

Details of Services

In the columns provided enter the appropriate fee code for each patient who received General Medical Services on the date service shown

Date Of Service / /

NHI NUMBER	PATIENT INITIAL & SURNAME	DATE OF BIRTH	FEE CODE	CSC / HUHC NUMBER	No. OF KM

	Y1	Y3	YZ	J1	J3	JZ	A1	A3	AZ
TOTAL SCHEDULE NUMBERS									

TOTAL KM

Re-order No. 48777