Medicare **DO NOT REMOVE COVER SHEET BEFORE IMPRINTING** DB1N

- **IMPORTANT** — When completing a DB1N form:
  a) use a **black ballpoint pen** to complete the form;
  b) do not submit **mixed batches** of DB2, DB3, DB4 and DB5 forms;
  c) to avoid problems with the processing of vouchers please ensure you clearly mark within the specified areas.
  EXAMPLE 1 2 3 4 5 OR 1 2 / 0 2 / 0 6 OR X
- This form is only used to claim assigned Medicare benefits for services rendered by one medical practitioner/optometrist from a single practice location.
- Claims for assigned Medicare benefits for services rendered to in-patients of a hospital or approved day hospital facility should be made using a DB1H form, not this form.
- Claims for assigned Medicare benefits for services classed as pre-admission, post-discharge or an outpatient service should be made using a DB1C form, not this form.
- The following steps should be taken when completing this form:
  1. Imprint the service provider's name and number using a Medicare provider card and imprinter, then discard the cover sheet; or remove the cover sheet and clearly write the provider's name and number in the relevant spaces. (Note: if the service provider does not have a provider number for the practice address from which the services were rendered, e.g. temporary locum, the provider number of another practice address is acceptable.)
  2. Complete all other sections such as date of claim, number of forms (no more than 80 vouchers should be contained in each claim) and amount claimed.
  3. Where payment is to be made to a provider other than the service provider ensure the PAYEE PROVIDER section is completed. (This is not necessary where a paygroup link facility has been set up.)
  4. The service provider must sign the form and have the signature witnessed in the relevant section.
  5. Place the form at the front of the batch of vouchers that make up this claim (please do not use staples to attach these forms).
  6. It is an offence under the *Health Insurance Act 1973* to make a false statement relating to Medicare benefits.

Designed 03/06

DETAILS OF SERVICE PROVIDER

– PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN –

NAME

ADDRESS

SERVICE PROVIDER NUMBER

Medicare 44 CLAIM FOR ASSIGNED BENEFITS FOR SERVICES RENDERED TO NON-HOSPITAL PATIENTS. (This form is the approved form as prescribed under section 20B 2 (a) of the *Health Insurance Act 1973*) DB1N

DATE OF CLAIM DD / MM / YY / /

CLAIM NUMBER

NUMBER OF ASSIGNMENT FORMS

TOTAL BENEFIT AMOUNT CLAIMED $.

DECLARATION BY PRACTITIONER OR OPTOMETRIST WHO RENDERED THE SERVICES
I claim Medicare benefits, being the amount specified in the column headed "Benefit Assigned", in respect of all the professional services specified in the attached assignment forms or claims transmission summary sheet, and I declare that:
- I authorise Medicare to pay benefits in respect of the attached assignment forms or claims transmission summary sheet, to the Practitioner specified below at or from whose practice the services were rendered.*

IMPORTANT Only complete this section if the payment is to be made to a provider other than the service provider.

* Print name of Practitioner _____

Payee's Provider Number

- To the best of my knowledge and belief all information contained in this claim is true.
- I accept the assignments in this claim.
- The professional services specified on the attached assignment forms or claims transmission summary sheet, were provided by me or on my behalf.
- To the best of my knowledge and belief the assignor(s) in respect of whom assignments have been accepted are entitled to make such assignments under 20A of the *Health Insurance Act 1973*.

- A copy of the assignment form was given to the assignor(s) after the right to benefit was assigned.
- No payments have been sought from any person in respect of the professional services specified in the attached assignment forms and claims transmission summary sheet.
- None of the amounts claimed is in respect of a professional service –
  (a) that was rendered to an in-patient of a hospital or approved day hospital facility.;
  (b) that was rendered in carrying out a mass immunisation, in connection with the patient's employment or in carrying out health screening (other than by providers approved by the Minister for Health and Ageing);
  (c) that was a medical examination for the purposes of Life Insurance, a Superannuation or Provident Account Scheme or admission to membership of a Friendly Society; or
  (d) which is precluded from Medicare benefit by any provision of the *Health Insurance Act 1973*.

Signature of Practitioner who rendered the services _____

Signature of Witness to above signature _____

Printed name of Witness _____ Date dd/mm/yy

Designed 03/06 Printed /06

HOLD BOTH ENDS FIRMLY – PULL TO SEPARATE

MEDICARE COPY

DETAILS OF SERVICE PROVIDER

– PLEASE COMPLETE THIS FORM IN BLACK BALLPOINT PEN –

NAME

ADDRESS

SERVICE PROVIDER NUMBER

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Signature of Practitioner who rendered the services _____

Signature of Witness to above signature _____

Printed name of Witness _____ Date dd/mm/yy

Designed 03/06

HOLD BOTH ENDS FIRMLY – PULL TO SEPARATE

PRACTITIONER COPY