DOCTOR ACCOUNT FORM

ATTACHMENT 2

Australian Health Service Alliance

Access Gap Cover

1. Practice Details

Practice Name

Provider's Name / Provider Number

2. Doctor Account Details

Patient Account Reference

Patient's Name | Date of Birth

Patient's Address | State | Postcode

Health Fund Name | Membership Number | Dependant Suffix

Facility at which the service was provided | Patient's Medicare Number | Patient Reference No | Valid to

MBS Item Number	Description of Service	Number of Patients Seen	Date of Service	Provider Number	Charge	Patient Co-Payment Amount	H-ST*
					$	$	
					$	$	
					$	$	
					$	$	
					$	$	
				TOTAL	$	$	

* Please tick if the service forms part of Hospital-Substitute Treatment (H-ST)

3. Request/Referral Details

Date | Referral Period

☐ 3 months ☐ 6 months ☐ 12 months ☐ 18 months ☐ Indefinite

Provider Name | Provider Number

Address | State | Postcode

4. Applicable Service Conditions

Compensation Related	❑ Yes	❑ No	Considered 'not for comparison'?	❑ Yes	❑ No
Part of a multiple procedure?	❑ Yes	❑ No	Self determined?	❑ Yes	❑ No
Referred within a hospital?	❑ Yes	❑ No	Performed on separate sites	❑ Yes	❑ No
Designated 'not normal' aftercare?	❑ Yes	❑ No	AM/PM?	❑ Yes	❑ No

5. Comments

This form may be photocopied or printed from our Website at www.ahsa.com.au/doctors

IMPORTANT NOTICE

PLEASE SEND CLAIMS TO THE PATIENTS HEALTH FUND (NOT TO AHSA)

Refer to the AHSA Participating Funds Contact List at www.ahsa.com.au/doctors