ACCOUNT SUMMARY FORM

ATTACHMENT 1

Access Gap Cover

1. Health Fund Details

Health Fund Name

Health Fund Address | State | Postcode

The medical practice has explained the billing process to the patient and the patient is fully aware of any co-payments charged.

2. Provider Details

Provider's Name

Provider Number | Telephone Number ( )

3. Batch Details

Account Summary Number (optional reference number) - Refer to explanation in the Billing Guide at Attachment 1. | Date

Total Fee Charged (including Gap) $ | Total Number of Claims | Total Amount Claimable $

4. Declaration

The professional services specified on the attached forms were provided by me or on my behalf.

The total amount charged is shown on the attached account/s to the fund, including any patient co-payments. Co-payments are within the allowable limits according to the Access Gap Cover Terms and Conditions and booking fees and the like have not been charged to the patient/s.

These services were performed whilst an admitted patient of a recognized hospital or day facility and/or the services form part of Hospital-Substitute Treatment.

All services in this batch are 'No Gap', i.e. the patient/s has nothing to pay ☐ Yes ☐ No, some or all services have a Gap

I have provided the patient/s with an 'Estimate of Medical Fees' form ☐ Yes ☐ No

I have disclosed any financial interests in the management of this patient/s ☐ Yes ☐ N/A

Signature | **Date**

May be signed by the provider or billing staff

5. Comments

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

This form may be photocopied