

Batch Summary



Section 1 - Provider Details

Provider Name			Provider Number:	
Practice Address				
Contact Name		Phone No.		Fax No.

Section 2 - Batch Details

Lodgement date		The Account Reference column must be completed. The other columns need to be completed if the requested information is not shown on the patient account.
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	Account Ref/ Surname	St.LukesHealth Member Number	Medicare Number	Medicare Card Reference	Hospital Name
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
Batch Total	\$				

Section 3 - Comments

Declaration

- Have the patients included in this batch been provided with an "Estimate of Medical Fees" and has informed financial consent been obtained? Yes No Not Applicable as "No Gap" applies
- Have you disclosed to all patients any financial interests you have in any product or service recommended or given to the patient? Yes No N/A

I declare that the services listed on the attached account(s) were provided by me or on my behalf and that the services were rendered to the patient(s) whilst admitted as a private patient of an approved hospital or day hospital facility.

This medical practice agrees to bill St.LukesHealth directly for the services listed on the attached account(s) and for these accounts accepts the operating, billing and claiming guidelines of the St. Luke's Gap Cover scheme as advised by St.LukesHealth.

Signature of authorised person		Name of authorised person	
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