Medicare copy

PATIENT DETAILS

FIRST NAME .... INITIAL

SURNAME ....

RESIDENTIAL ADDRESS ....

DATE OF BIRTH DD / MM / YYYY ....

MEDICARE NUMBER

PATIENT REF. No.   EXPIRY DATE CHECKED ☒

DATE OF SERVICE DD / MM / YY

I assign my right to benefits to the dental provider who has rendered the service(s).   Patient unable to sign ☐

✍ .... / /
SIGNATURE OF PATIENT   DATE

DB2-DB(a).1405

medicare   **ASSIGNMENT FORM**   (This form is the approved form as prescribed under section 12(2) of the *Dental Benefits Act 2008*)   **DB2-DB**

ITEM NO.	DESCRIPTION OF SERVICE (optional)	BENEFIT ASSIGNED
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		.
		.

Dental provider who rendered the above service(s) Name   Provider number

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Practitioner copy

Patient copy