abn 83 000 124 381
nib MediGap Department
Reply Paid 62208
NEWCASTLE NSW 2300
Phone 1300 853 530 (option 1)
Fax 02 4925 1906
Email medigap@nib.com.au
Web providers.nib.com.au

This medical practice agrees to bill nib MediGap directly for the services on this account and accepts the terms of MediGap as set out in the current Products & Procedures Guide. The patient/nib customer has been advised of the payment arrangements for the services on this account and no further payment is required.

**nib MediGap is a NO GAP scheme.**

# BATCH HEADER OR ACCOUNT FORM

Instructions
- Complete parts 1 and 4 if attaching your own accounts. (Your accounts much include all information in parts 2 and 3)
- Complete parts 1, 2, 3 and 4 if using this form as your account.

## PART 1 - BATCH DETAILS

Provider's name

Provider's number

Date lodged

Number of claims in batch

Total value of claims in batch $

## PART 2 - ACCOUNT DETAILS

Patient's name

nib customer number

*Medicare no.

*Patient reference no.

***Please ensure correct Medicare and Reference No's are stated***

Patient's date of birth

Customer's name *(if not the same as the Patient)*

Hospital name

Hospital provider number

Your reference number

Total charge

***Referral details***

Referral date

Referral period: 3 months ☐ 6 months ☐ 12 months ☐ 18 months ☐ Indefinite ☐

Referring doctor's name

Referring doctor's provider number

## PART 3 - SERVICE DETAILS

**Service conditions - tick (✓) below if applies to each service**

| MBS Item no. | Description of service | Number of patients | Date of Service | Full cost of service | Part of a multiple procedure | Referred within a hospital | Designated 'not normal' after care | Considered 'not for comparison' | Performed on separate sites | Self determined |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2 | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3 | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4 | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Assisting doctor's name

Assisting doctor's provider number

Surgeon's name

Surgeon's provider number

## PART 4 - AUTHORISATION

- Are the services on this claim related to compensation? Yes ☐ No ☐
- Does your practice have financial interests in any hospital or health insurance product? Yes ☐ No ☐
- Has the patient/nib customer been provided with informed financial consent? Yes ☐ No ☐

**Declaration**

The professional services on the attached account were provided by or on behalf of a doctor in this practice and were rendered to a private in-patient of a hospital or registered day hospital facility.

I declare that the charges above are full cost for services provided and that no additional charges have been placed on the customer for those services.

**Signature of authorised person**

**Date**

**For assistance or more information, please call the MEDIGAP HOTLINE 1300 853 530 (option 1)**