

Please complete in BLOCK CAPITALS and tick ☒ as appropriate

Patient's details

Date if claim sent electronically

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS
No.

Previous surname/s

Home address

Temporary address, if applicable

Postcode

Postcode

Telephone number

Telephone number

Details of treatment should be sent to

Doctor's name and full address

To be completed by the doctor

Emergency treatment

☐ Immediately necessary treatment

Contraceptive services

☐ non-IUD ☐ IUD

☐ Minor surgical operation

Temporary resident

Number of
night visits

☐ Treatment of fracture

Date of initial treatment

☐ General anaesthetic

☐ up to 15 days

Dental haemorrhage

☐ Reduction of dislocation

☐ over 15 days

☐ Rate A ☐ Rate B

☐ Other

☐ Telephone advice only

Number of vaccinations & immunisations

☐ Telephone advice only

☐ Amended claim

fee A fee B

☐ Rural practice payment. Distance in miles from patient's temporary residence to my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as in the SFA. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised signature

Practice stamp

Name

Date



Temporary services

GMS3/99

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Do not write on this tinted area

In case of queries, contact:
at: