Terry Potts
B.D.S. (SYD. UNI.)
DENTAL SURGEON
PROV. NO. 520954-Y
John Amsden
B.D.S. (OTAGO)
DENTAL SURGEON
PROV. NO. 2127213-X
Pamela Hall

SUITE 4 EASTPOINT ARCADE
JONSON STREET, BYRON BAY 2481
P.O. BOX 14, BYRON BAY 2481
TELEPHONE: (02) 6685 8137
FAX: (02) 6685 8187

ACCOUNT
15324

NAME	ADDRESS	DATE
HAMILTON	PETER	6-4-01

ITEM NUMBER	DETAILS OF TREATMENT	FEE
533	3 surface adhesive resin	85-
577	1 cusp overlay	
	TOTAL	$ 85-

Date	Rec. No.	Name	Cash	Bankcard	Medicare Cheque	Other Cheque
6.4.21	283	HAMILTON, Peter	85 —			

METHOD OF PAYMENT

❑ TERRY POTTS
B.D.S. (Syd Uni.)
Provider No. 520954 Y

❑ JOHN AMSDEN
B.D.S. (Otago)
Provider No. 2127213 X

DENTAL SURGEONS

SUITE 4,
EASTPOINT ARCADE, JONSON STREET,
P.O. BOX 14
BYRON BAY NSW 2481

TELEPHONE: (02) 6685 8137
FACSIMILE: (02) 6685 8187

0283

Per _____

Received with Thanks

Medicare

It is an offence, under the *Health Insurance Act 1973* to make a false or misleading statement. Medicare benefits are only payable to the person who incurs the medical expense.

* Attach original itemised accounts or receipts behind here

Section 1. Claim and payment details

1. Patient's Medicare card number: 2 2 2 3 9 3 6 8 1 4

2. What is the name of the person who paid for or is liable to pay for the medical expenses?

(Title e.g. Mr/Mrs/Miss/Ms)	(Family name)	(Given name)
Mr	HAMILTON	Peter I

(Payments will be addressed to this person. For benefits to be paid in favour of this person, the account must be paid for in full)

3. What is your current mailing address?

1/50 Paterson St, Byron Bay, 2481

Postcode 2481

4. Is this your permanent mailing address? Yes [✓] No [ ]

If 'Yes', Medicare records will be updated to reflect this.

5. What telephone number can you be contacted on during business hours? (02) 66-858-648

6.

CARD REF. No.	PATIENT'S FIRST GIVEN NAME & INITIAL e.g. *ROBIN*	*G*	FOR SERVICES PROVIDED BY e.g. *Dr. A. P. JONES*
	Peter	H	Dr. Pamela Hall

7. Have any of the services being claimed been paid in full? Yes [✓] No [ ]

If 'Yes' ensure section 2 is completed. If 'No' a cheque will be made out to the doctor and mailed to the person specified in question 2 above.

Section 2. Electronic Funds Transfer (EFT) details

1. Do you want the benefit to be deposited directly into a bank account via EFT? Yes [ ] No [✓]
(This option is only available for paid accounts.) **If 'No' then go straight to section 3.**

2. Name the account is held in:

3. BSB number (6 digits in total) [ ][ ][ ] [ ][ ][ ]

Bank account number (up to 10 digits only) [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

(If you are unsure of the BSB number, please contact the bank where the account is held.)

4. Bank name: Branch:

5. A Statement of Benefit will only be issued automatically where in-hospital services are included in this claim and the benefit is paid via EFT. If you need a statement for other services, please tick this box. [ ]

Section 3. In-hospital services

1. Was the patient(s) an in-patient of a hospital or approved day hospital facility? Yes [ ] No [✓]

2. If 'Yes', what was the name of the hospital?

3. What were the dates of admission and discharge? Admitted / / Discharged / /

Section 4. Adding a newborn child

You can add your newborn child to the above Medicare card by completing this section. In some circumstances you may be asked to provide identification documents.

(Family name) (Child's given name) (2nd initial)

Sex M/F [ ] Date of birth / /

Section 5. Claimant declaration

I hereby claim Medicare benefits for the professional services to which this claim relates and I declare that:

- I have paid for or am liable to pay the expenses for these services.
- The services were not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with the patient's employment.
- To the best of my knowledge and belief all the information in this claim is true and correct.

I also authorise Medicare to contact the referring practitioner or the provider of the services if clarification of details on accounts/receipts is required for assessment purposes.

Signature of claimant: P P Hamilton Date: 6/4/01

(The person who incurred the expense.)

* All documents supporting this claim will be retained by Medicare.
Information regarding the Medicare Safety Net can be found on the reverse of this form.

Agent's Authority

Only complete this section if authorising another person to collect cash on your behalf. Your agent will be asked to provide satisfactory personal identification.

Agent's Name

Address

Postcode

Agent's Signature **Claimant's Signature**

CLAIM FORM - This form is the approved form under section 20B of the *Health Insurance Act 1973*. For payment by electronic funds transfer (EFT), cheque, or cash to an authorised agent.

PC1 05/98

Enquiries

Any enquiries about Medicare may be made by telephoning the national enquiries on **132 011** (for the cost of a local call).

Remember – Immunisation Saves Lives

How to claim

- **A claim form does not need to be completed for paid accounts presented at a Medicare customer service centre for cash or EFT.**
  If you have already paid the account the receipt must be attached. You can obtain payment:
  (a) in cash up to a specified limit at a Medicare customer service centre. Please present your Medicare card when claiming; or
  (b) by EFT directly into a nominated bank account (Note: If your bank rejects the EFT a cheque will be issued to the claimant through the post); or
  (c) by cheque through the post (do not send in your Medicare card). The cheque will be issued in the claimant's name and posted to the claimant's address as shown on this claim form. Claims should be addressed to **G.P.O. Box 9822 in your capital city.** (Note: Payment by EFT offers a faster payment time than by cheque.)
- If you have not paid the account, a cheque will be issued in the practitioner's name but posted to you for forwarding to the practitioner with any balance due.

Gap benefits

Medicare benefits are based on the Schedule fee for the service rendered. The difference between the **Medicare benefit and Schedule fee** is called the gap. People who have hospital insurance with a registered health benefits fund and incur medical expenses in hospital can claim benefits from the fund for the gap amounts, provided Medicare benefits are payable for the services. People claiming Medicare benefits for in-hospital services will be provided with a statement of benefits, which can be used to support a claim on their private health fund for gap benefits. Alternatively, for participating private health funds, under a Two Way Agency arrangement claims for gap benefits can be forwarded, on your behalf, directly to your fund. Complete a Gap/ancilliary claim form available in Medicare customer service centres and attach to your Medicare claim.

The Medicare Safety

The Medicare Safety Net is designed to protect all people who frequently see the doctor and have high medical expenses.
The Safety Net does not apply to in-hospital services.
When gap payments made by an individual, or a registered family, reach a threshold amount in a calendar year, Medicare will refund 100% of the schedule fee for the remainder of that year. The Safety Net threshold amount is indexed to the CPI and is adjusted annually. For details of the current Medicare Safety Net threshold contact your nearest Medicare customer service centre or telephone Medicare enquiries on 132 011.
For further details on the Medicare Safety Net ask for a brochure at a Medicare customer service centre or telephone 132 011.

Excluded services

Listed below are some of the services for which Medicare benefits are not payable:

- a medical examination for the purpose of life insurance, a superannuation or provident account scheme or admission to membership of a friendly society;
- a service rendered by or on behalf of the Commonwealth, a State, a local governing body or an authority established by a law of the Commonwealth, a State or a law of an internal Territory; and
- a service where the medical expense is the responsibility of the employer of the patient, mass immunisation programs, health screening services not reasonably required for the management of the patient's medical condition.

Privacy note

The information provided by you on this form and the attached accounts or receipts will be used to pay your claim. Its collection is authorised by law and may be disclosed to the Department of Health and Family Services or a person associated with the claim. Enrolment information will be used to maintain a record of entitled persons for the Government programs administered by the Health Insurance Commission, and by law may be disclosed to the Department of Veterans' Affairs, Department of Social Security and Commonwealth Services Delivery Agency.

M/C No.

MANUAL ASSESSMENT

Ref. No.	Patient's First Name	Item	DATE OF SERVICE Day	Month	Year	Provider No.	Charge	Schedule Fee	Benefit	Referral

Office Use Only

Pd Cash.
Claim posted 9-4-01 with not.

Medicare

MEDICARE EFT STATEMENT ONLY NSW PHONE 132 011

050700 000779 RUN 128, 07/07/00 **PROVIDER DETAILS**

0587612A DR K O HROMEK

8 294

MR P HAMILTON
1/50 PATERSON ST
BYRON BAY NSW 2481

CARD NO 2223 93681 3
BSB NO 082-489
NATIONAL - TRADING
BYRON BAY 33 JONSON ST
A/C NO 509751472
A/C NAME P I P HAMILTON

PATIENT NAME	PROV NO	DATE	NO	ITEM	CHARGE	SCH FEE	BENEFIT EXP
HAMILTON,PETER I	0587612A	030700	1	23	30.00	26.45	22.50
				TOTALS	30.00		22.50
				TOTAL EFT AMOUNT			$22.50

Medicare

MCC-001
1196

CARD: 2223936813

...../.....

13/7/09

Dear Claimant

Before we can process the enclosed documents, we need you to fulfil the requirements as indicated below by "✓".

- ☐ Sign the claim form.
- ☐ Include the hospital accommodation details on the claim form.
- ☐ Complete the enclosed claim form.
- ☐ Attach the receipts to the paid account/s.
- ☑ Attach detailed accounts from Dr Moore with Referral details - not just receipt
- ☐ Provide original accounts/receipts. (Alternatively, your copies should be certified by the practitioner/s).
- ☐ Attach Statements of Benefits to the enclosed receipts, for substantiation purposes.
- ☐ .....

When you have done this, please return the claim for us to finalise.

If we are able to process part of your claim, an assessment advice/cheque will be mailed separately.

Our Enquiries staff will be pleased to assist you with any questions you may have about this letter. The number to call is shown below.

Yours faithfully

(for) Manager Medicare
NSW/ACT
Enc.

Medicare

It is an offence, under the *Health Insurance Act 1973* to make a false or misleading statement. Medicare benefits are only payable to the person who incurs the medical expense.

* Attach original itemised accounts or receipts behind here

Section 1. Claim and payment details

1. Patient's Medicare card number 2 2 2 3 9 3 6 8 1 3

2. What is the name of the person who paid for or is liable to pay for the medical expenses?

(Title e.g. Mr/Mrs/Miss/Ms)	(Family name)	(Given name)
Mr	Hamblett	Robert

(Payments will be addressed to this person. For benefits to be paid in favour of this person, the account must be paid for in full)

3. What is your current mailing address?

Unit 1, 50 Rt 5 RSD.

Postcode

4. Is this your permanent mailing address? Yes ☐ No ☐

If 'Yes', Medicare records will be updated to reflect this.

5. What telephone number can you be contacted on during business hours? ( )

6.

CARD REF. No.	PATIENT'S FIRST GIVEN NAME & INITIAL e.g. *ROBIN*	G	FOR SERVICES PROVIDED BY e.g. *Dr. A. P. JONES*
			Dr SH. Moore

7. Have any of the services being claimed been paid in full? Yes ✓ No ☐

If 'Yes' ensure section 2 is completed. If 'No' a cheque will be made out to the doctor and mailed to the person specified in question 2 above.

Section 2. Electronic Funds Transfer (EFT) details

1. Do you want the benefit to be deposited directly into a bank account via EFT? Yes ✓ No ☐
(This option is only available for paid accounts.) **If 'No' then go straight to section 3.**

2. Name the account is held in: R P Hamblett

3. BSB number (6 digits in total) 0 8 2 4 8 9

Bank account number (up to 10 digits only) 5 0 9 7 5 1 4 7 2

(If you are unsure of the BSB number, please contact the bank where the account is held.)

4. Bank name: NAB Branch: BB

5. A Statement of Benefit will only be issued automatically where in-hospital services are included in this claim and the benefit is paid via EFT. If you need a statement for other services, please tick this box. ☐

Section 3. In-hospital services

1. Was the patient(s) an in-patient of a hospital or approved day hospital facility? Yes ☐ No ☐

2. If 'Yes', what was the name of the hospital?

3. What were the dates of admission and discharge?

	Admitted	Discharged
	/ /	/ /

Section 4. Adding a newborn child

You can add your newborn child to the above Medicare card by completing this section. In some circumstances you may be asked to provide identification documents.

(Family name)	(Child's given name)	(2nd initial)
COPY		

Sex M/F ☐ Date of birth / /

Section 5. Claimant declaration

I hereby claim Medicare benefits for the professional services to which this claim relates and I declare that:

- I have paid for or am liable to pay the expenses for these services.
- The services were not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with the patient's employment.
- To the best of my knowledge and belief all the information in this claim is true and correct.

I also authorise Medicare to contact the referring practitioner or the provider of the services if clarification of details on accounts/receipts is required for assessment purposes.

Signature of claimant: RH Date: 21/6/99

(The person who incurred the expense.)

* All documents supporting this claim will be retained by Medicare.
Information regarding the Medicare Safety Net can be found on the reverse of this form.

Agent's Authority

Only complete this section if authorising another person to collect cash on your behalf. Your agent will be asked to provide satisfactory personal identification.

Agent's Name

Address

Postcode

Agent's Signature **Claimant's Signature**

CLAIM FORM - This form is the approved form under section 20B of the *Health Insurance Act 1973*. For payment by electronic funds transfer (EFT), cheque, or cash to an authorised agent.

PC1 05/98

Enquiries

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Recent 21/7/99

Remember – Immunisation Saves Lives

How to claim

- **A claim form does not need to be completed for paid accounts presented at a Medicare customer service centre for cash or EFT.** If you have already paid the account the receipt must be attached. You can obtain payment:
  - (a) in cash up to a specified limit at a Medicare customer service centre. Please present your Medicare card when claiming; or
  - (b) by EFT directly into a nominated bank account (Note: If your bank rejects the EFT a cheque will be issued to the claimant through the post); or
  - (c) by cheque through the post (do not send in your Medicare card). The cheque will be issued in the claimant's name and posted to the claimant's address as shown on this claim form. Claims should be addressed to **G.P.O. Box 9822 in your capital city.** (Note: Payment by EFT offers a faster payment time than by cheque.)
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Excluded services

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- a medical examination for the purpose of life insurance, a superannuation or provident account scheme or admission to membership of a friendly society;
- a service rendered by or on behalf of the Commonwealth, a State, a local governing body or an authority established by a law of the Commonwealth, a State or a law of an internal Territory; and
- a service where the medical expense is the responsibility of the employer of the patient, mass immunisation programs, health screening services not reasonably required for the management of the patient's medical condition.

Privacy note

The information provided by you on this form and the attached accounts or receipts will be used to pay your claim. Its collection is authorised by law and may be disclosed to the Department of Health and Family Services or a person associated with the claim. Enrolment information will be used to maintain a record of entitled persons for the Government programs administered by the Health Insurance Commission, and by law may be disclosed to the Department of Veterans' Affairs, Department of Social Security and Commonwealth Services Delivery Agency.

M/C No.

MANUAL ASSESSMENT

Ref. No.	Patient's First Name	Item	DATE OF SERVICE Day	Month	Year	Provider No.	Charge	Schedule Fee	Benefit	Referral

Office Use Only

Dr Stephen M Moore

B MED SC, MB BS (HONS UNSW), FRACP

69 Uralba St, Lismore NSW 2480
Ph (02) 6622 2326
Fax (02) 6622 2342

CONSULTANT PHYSICIAN

PN 471263B

Invoice

INVOICE # 1969

PATIENT	PETER HAMILTON Unit 1/ 50 Patteson Street BYRON BAY 2481

REFERRED BY	DR KARL HROMEK PN. 587612A 26.5.99

DATE	ITEM NUMBER	SERVICE	FEE
26/05/99	110	Initial Consultation	114.35

App form on back
26/5/99
Medicare.

Duplicate of this
sent 21/7/99

Total	$114.35

Rect. 049798
26/5/98
$114.35

Medicare

Statement of Benefit

PLEASE RETAIN FOR TAXATION PURPOSES

PAID IN FAVOUR OF PROVIDER

NSW PHONE 132 011

250900 018023 1/1 RUN 195, 09/10/00

PROVIDER DETAILS

0081601B DR P P LAIRD

6 294

MR P HAMILTON
1/50 PATERSON ST
BYRON BAY NSW 2481

99870577

MEDICARE CARDNUMBER 2223 93681 3

PATIENT NAME	PROV NO	DATE	NO	ITEM	CHARGE	SCH FEE	BENEFIT EXP
HAMILTON,PETER I	0081601B	020800	1	11503	106.65	106.65	80.00+
				TOTALS	106.65		80.00
				TOTAL CHEQUE AMOUNT			$80.00

EXPLANATION OF CODES

\+ INPATIENT SERVICE - MAY BE ELIGIBLE FOR PRIVATE FUND GAP BENEFIT

Not claimable on Medicare

FORWARD THIS STATEMENT AND CHEQUE TO DR P P LAIRD TOGETHER WITH ANY BALANCE DUE

PATIENT NAME	PROV NO	DATE	NO	ITEM	CHARGE	SCH FEE	BENEFIT EXP
HAMILTON,PETER I	0081601B	020800	1	11503	106.65	106.65	80.00+
				TOTALS	106.65		80.00
				TOTAL CHEQUE AMOUNT			$80.00

EXPLANATION OF CODES

\+ INPATIENT SERVICE - MAY BE ELIGIBLE FOR PRIVATE FUND GAP BENEFIT

Not forwarded.

PH.
16/10/00

PAUL P. LAIRD
B.Sc. (Med.), M.B., B.S. F.R.A.C.P.
CONSULTANT PHYSICIAN

99 URALBA STREET
LISMORE 2480

POSTAL ADDRESS:
P.O. BOX 38
LISMORE N.S.W. 2480

TELEPHONE:
(02) 66214465
FAX (02) 66222981

PROVIDER NUMBER 081601B
P.P. LAIRD PTY.LTD.
A.C.N. 002 910 456

Mr P. HAMILTON
1/50 Paterson Street
BYRON BAY 2481

Receipt

20/11/2000

Receipt N°: 5214

Being for

Acc	Date	Services/Patient	Fee	Paid
6968	2/8/2000	11503, Sleep Study	$106.65	$80.00
		HAMILTON,Peter	$80.00	$80.00

Previous credit: $0.00
Cheques:

Received with thanks.

Credit card: $0.00
Cash: $80.00

Total payment this receipt: $80.00

Balance still outstanding (on 20/11/2000): $0.00

Not claimable on Medicare

Medicare

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* Attach original itemised accounts or receipts behind here

Section 1. Claim and payment details

1. Patient's Medicare card number

2. What is the name of the person who paid for or is liable to pay for medical expenses?

(Title e.g. Mr/Mrs/Miss/Ms) (Family name) (Given name)

(Payments will be addressed to this person. For benefits to be paid in favour of this person, the account must be paid for in full)

3. What is your current mailing address?

Postcode

4. Is this your permanent mailing address? Yes No

If 'Yes', Medicare records will be updated to reflect this.

5. What telephone number can you be contacted on during business hours? ( )

6.

CARD REF. No.	PATIENT'S FIRST GIVEN NAME & INITIAL e.g. *ROBIN* *G*	FOR SERVICES PROVIDED BY e.g. *Dr. A. P. JONES*

7. Have any of the services being claimed been paid in full? Yes No

If 'Yes' ensure section 2 is completed. If 'No' a cheque will be made out to the doctor and mailed to the person specified in question 2 above.

Section 2. Electronic Funds Transfer (EFT) details

1. Do you want the benefit to be deposited directly into a financial institution account via EFT? (This option is only available for paid accounts.) Yes No

If 'No' then go straight to section 3.

2. Name the account is held in:

3. BSB number (6 digits in total) Financial institution account number (up to 9 digits only)

(If you are unsure of the BSB number, please contact the financial institution where the account is held.)

4. Financial institution: Branch:

5. A Statement of Benefit will only be issued automatically where in-hospital services are included in this claim and the benefit is paid via EFT. If you need a statement for other services, please tick this box.

Section 3. In-hospital services

1. Was the Patient(s) an in-patient of a hospital or approved day hospital facility? Yes No

2. If 'Yes', what was the name of the hospital?

3. What were the dates of admission and discharge? Admitted / / Discharged / /

Section 4. Adding a newborn child

You can add your newborn child to the above Medicare card by completing this section. In some circumstances you may be asked to provide identification documents.

(Family name) (Child's given name) (2nd initial)

Sex M/F Date of birth / /

Section 5. Claimant declaration

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I also authorise Medicare to contact the referring practitioner or the provider of the services if clarification of details on accounts/receipts is required for assessment purposes.

Signature of claimant: Date: / /

(The person who incurred the expense.)

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Agent's Name

Address

Postcode

Agent's Signature **Claimant's Signature**

Enquiries

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M/C No.

MANUAL ASSESSMENT

Ref. No.	Patient's First Name	Item	DATE OF SERVICE Day	Month	Year	Provider No.	Charge	Schedule Fee	Benefit	Referral

Office Use Only