Form 03
Assignment of Benefits
Send to: admin@acmns.au

Assignment of Medicare Benefits (Bulk Billed Service)

Patient Details Full Name: _____

Date of Birth: _____

Medicare Card Number: _____

Service Details Date of Service: _____

Description of Service: _____

(If known: MBS Item Number(s): _____)

Provider Details Practice Name: ACMNS Treating Practitioner: _____

Important Information By signing this form, I understand and agree to the following:

- I am assigning my Medicare benefit(s) for the above service directly to the provider (ACMNS).
- The assigned Medicare benefit will be accepted as full payment for the service. I will not be charged any out-of-pocket costs.
- I will not claim any Medicare benefit for this service myself.
- The provider will submit the claim to Medicare on my behalf.

Agreement I confirm that I have read and understood the information above. I agree to assign my Medicare benefit to the provider as full payment for the service.

Signature Signed by:

The patient Signature: _____

Printed Name: _____

Date: _____