**Form 04**
**Assignment of Benefits (proxy)**
Send to: admin@acmns.au

**Assignment of Medicare Benefits (Bulk Billed Service) – Signed by Responsible Person/proxy**

**Patient Details** Patient 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: _____

**Responsible Person (Proxy) Details** Your Full Name: _____

Your Relationship to Patient: _____ (e.g. parent, guardian, spouse, power of attorney)

**Declaration** ☐ I confirm the patient is unable to sign this agreement themselves. Reason (optional): _____

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

- I am the responsible person for the patient named above.
- I am assigning the patient's 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. The patient will not be charged any out-of-pocket costs.
- No Medicare benefit will be claimed by the patient for this service.
- The provider will submit the claim to Medicare on the patient's behalf.

**Agreement** ☐ I confirm that I have read and understood the information above. I agree to assign the patient's Medicare benefit to the provider as full payment for the service.

**Signature** Signed by:

Responsible person / Proxy (on behalf of the patient)

Signature: _____

Printed Name: _____

Date: _____