



CLAIM FORM FOR LEAD MATERNITY CARER, FIRST AND SECOND TRIMESTER



MANATŪ HAUORA

Please ensure completed forms are attached to the Claim Summary and send to: HealthPAC, Health Payments, Agreements and Compliance, P.O. Box 1026, Wellington 6140.

LEAD MATERNITY CARER DETAILS

PRACTITIONER TYPE Medical Council of New Zealand Midwifery Council of New Zealand REGISTRATION NUMBER

PRACTITIONER NAME

WOMAN DETAILS

NHI NUMBER

EDD

DETAILS OF SERVICE PROVIDED

Number of Visits in the First Trimester

Number of Visits in the Second Trimester

DETAILS OF CLAIM

Date Module Ended Tick applicable box Full Module First Partial Last Partial Amount Claimed (GST exclusive) \$:

REASON SERVICE COMPLETED

Woman moved to next module of care Woman has changed Maternity Provider Woman has transferred to Secondary Care Woman has had a miscarriage Woman has had a termination

SAMPLE ONLY - NOT TO SCALE