



CLAIM FORM FOR NON-LMC FIRST TRIMESTER SERVICES



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.

PRACTITIONER DETAILS

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

PRACTITIONER NAME

WOMAN DETAILS

NHI NUMBER EDD LMP (estimate if necessary)

DETAILS OF SERVICE PROVIDED

Number of Visits in the First Trimester

DETAILS OF CLAIM

Date Module Ended Without miscarriage or termination With miscarriage or termination

Amount Claimed (GST exclusive) \$:

REASON SERVICE COMPLETED

Woman transferred to LMC Care
 Woman has transferred to Secondary Care
 Woman has had a miscarriage
 Woman has had a termination
 Woman has changed PHO practice

SAMPLE ONLY - NOT TO SCALE