370006 HP Primary Maternity

PRIMARY MATERNITY SERVICES CLAIM SUMMARY FORM

MINISTRY OF HEALTH
MANATŪ HAUORA

Please send completed forms to: **HealthPAC, Health Payments, Agreements and Compliance, P.O. Box 1026, Wellington 6140.**

MATERNITY PROVIDER DETAILS

PAYEE NUMBER ☐☐☐☐☐☐ **AGREEMENT NUMBER** ☐☐☐☐☐☐ – ☐☐

AGREEMENT HOLDER'S NAME

CLAIM REFERENCE

DETAILS OF CLAIM

Number of Forms Attached (including this form)

Grand Total Amount Claimed (GST exclusive) $:

GST (if GST registered) $:

Grand Total Amount Claimed (GST inclusive) $:

CERTIFICATION

I understand that:

- the Ministry of Health will use the information in this application form in a manner consistent with the Privacy Act 1993 to process claims for the provision of primary maternity services made under the Primary Maternity Services Notice 2007;
- the information in this application form will be held securely by the Ministry and will be kept confidential except when required to be disclosed by law.

I certify that:

- I/we have complied with the conditions (if any) of my/our authorisation to claim under the Primary Maternity Services Notice 2007 issued by the Ministry of Health;
- the information contained in this form is true and correct.

Date ☐☐/☐☐/☐☐

Authorisation Holder's Signature

HEALTHPAC ONLY

Total Number of Forms Entered

Total Amount Paid (GST exclusive) $:

Entered By Date ☐☐/☐☐/☐☐

Certified By Date ☐☐/☐☐/☐☐

Re-order No. 94489 03/07

SAMPLE ONLY – NOT TO SCALE