CENTRAL VICTORIAN ANAESTHETIC SERVICE

104 BAXTER STREET, BENDIGO, VIC 3550
(PO BOX 755, BENDIGO, VIC, 3552)
PHONE: 03 5443 6155
FAX: 03 5441 3858
EMAIL: office@cvas.com.au
WEB: www.cvas.com.au

ANAESTHESIA BOOKING FORM

Medicare Number:			Individual Ref # of patient
Family Name of Patient:			Mr / Mrs / Miss / Ms / Mst / Other
First Name:			**Middle Name:**
Date of Birth: / /	**M /F**		**Name of person responsible for this account:**
Residential Address:			
Postal Address: (If different to above)			
Mobile Phone:			**Home Phone:**
Work Phone:			**Fax:**
Email:			**Tick if you prefer communication via Post**

Health Fund Company:	**Membership Number:**
Are you eligible for Gap Cover? (Confirm with your Health Fund) **Yes** **No**	**Policy Name:** **Basic / Intermediate / Top Table**

It is your responsibility to check with your health fund that your procedure will be covered by your policy.

If there is any doubt about your eligibility for cover please contact this office prior to your procedure.

Self Pay: (if applicable) If you would like us to lodge your claim with Medicare tick this box to authorise us to do so:

If the patient is under 18 years: Parent Name: Relationship to patient:

Address: (if different to above)

Parent or guardian's Date of Birth (for Medicare Purposes): / / Medicare Card Individual Ref # of parent: (for Medicare Purposes):

Pension Number:	**Workcover Claim Number:** **Insurance Company:**
DVA Number: **Card Colour:**	**TAC Claim Number:**

DETAILS OF SURGERY/PROCEDURE/ITEM NUMBERS:

Item Numbers:			
Date of Procedure:	**Approximate Duration:**	**Hospital:**	**Surgeon:**

To be eligible for the maximum Health Fund rebate you must have a written estimate prior to your procedure.
The estimate will be provided on return of this completed form by email, fax, post or in person to our office.