Australian Health Service Alliance

Access Gap Cover

ACCESS GAP COVER **ACCOUNT SUMMARY**

1. Health Fund Details

Health Fund Name

Health Fund Address | State | Postcode

The medical practice has explained the billing process to the patient and the patient is fully aware of any co-payments charged

2. Provider Details

Provider's Name

Provider Number | Telephone Number ( )

3. Batch Details

Account Summary Number (Refer to Page 17 of the Billing and Business Guidelines Brochure) | Date / /

Total Fee Charged $ | Total Number of Claims | Total Amount Claimable $

4. Declaration

The professional services specified on the attached forms were provided by me or on my behalf.

The total amount charged is shown on the attached account/s to the fund, including any patient co-payments. Co-payments are within the allowable limits according to the Access Gap Cover Billing and Business Guidelines Brochure and booking fees have not been charged to the patient/s.

These services were performed whilst an admitted patient of a recognised hospital or day facility and/or the services form part of Hospital-Substitute Treatment approved by AHSA.

All services in this batch are "No Gap", i.e. the patient/s has nothing to pay ☐ Yes ☐ No, some or all services have gaps

I have provided the patient/s with an 'Estimate of Medical Fees' form ☐ Yes ☐ No

I have disclosed any financial interests in the management of the patient/s ☐ Yes ☐ N/A

Signature | **Date** / /

May be signed by the doctor or billing staff

5. Comments

IMPORTANT

SEND CLAIMS TO THE PATIENTS HEALTH FUND (NOT AHSA)

Refer to the AHSA Participating Funds Contact List Brochure

This form may be photocopied or printed from our website: www.ahsa.com.au

For further information please feel free to contact an AHSA office
Freecall Phone 1800 664 277 **Freecall Fax** 1800 670 898 **Email** access@ahsa.com.au

Attachment 1