Temporary services

GMS3/99

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

Patient's details

Date if claim sent electronically

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

Home address

Temporary address, *if applicable*

Postcode

Postcode

Telephone number

Telephone number

Details of treatment should be sent to

Doctor's name and full address

To be completed by the doctor

Emergency treatment

- ○ Minor surgical operation
- ○ Treatment of fracture
- ○ General anaesthetic
- ○ Reduction of dislocation
- ○ Other
- ○ Telephone advice only

- ○ **Immediately necessary treatment**

Temporary resident

Date of initial treatment

- ○ up to 15 days
- ○ over 15 days
- ○ Telephone advice only
- ○ Amended claim

Contraceptive services

○ non-IUD IUD

Number of night visits

Dental haemorrhage

Rate A Rate B

Number of vaccinations & immunisations

fee A fee B

☐ Rural practice payment. Distance in miles from patient's temporary residence to my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as in the SFA. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised signature

Practice stamp

Name

Date

Do not write on this tinted area

In case of queries, contact:
at: