



Please complete in BLOCK CAPITALS and tick  as appropriate

## Patient's details

## Date if claim sent electronically

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

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

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



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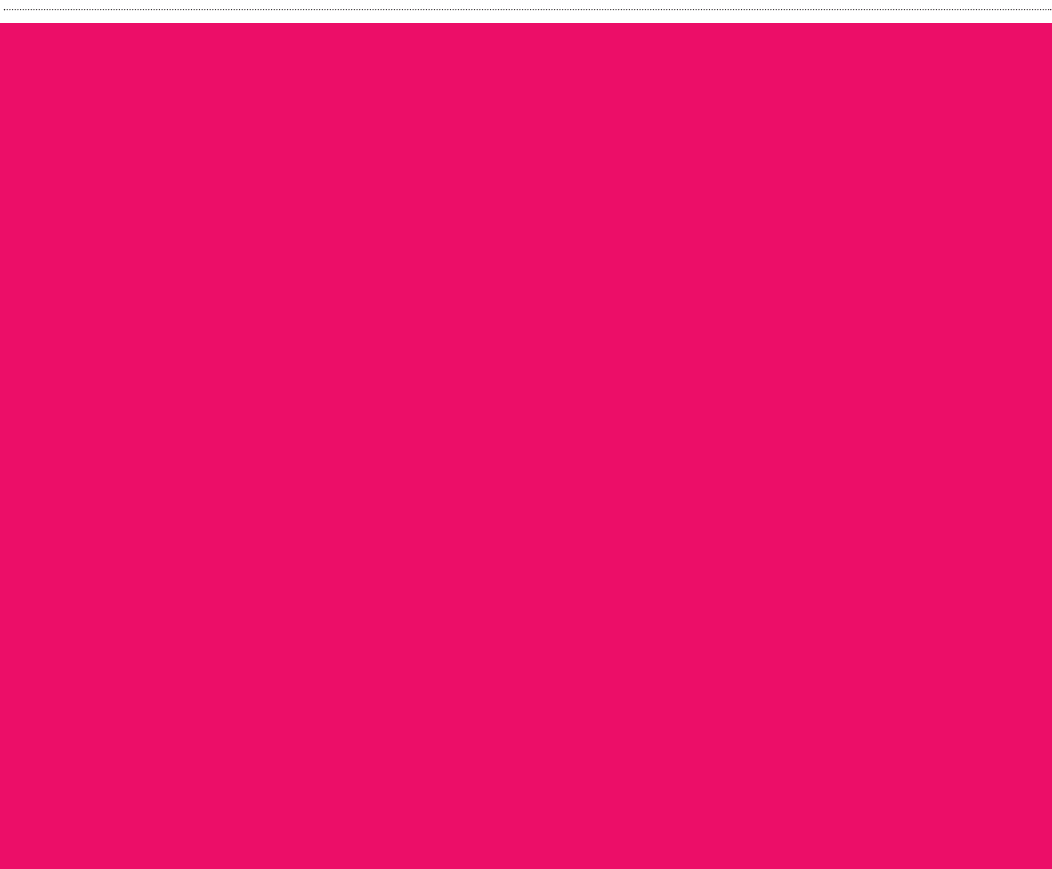
Postcode

Telephone number

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Do not write on this tinted area

In case of queries, contact:  
at: