



DEPARTMENT OF HEALTH

FACSIMILE

TO: MEDICARE AUSTRALIA
Fax 8922 6322

FROM: NAME
CLINIC
FAX
PHONE

DATE: Wednesday, 19 October 2011

- (Tick One) [ ] Please tell us the Medicare number for the following person.
[ ] Please change the following person's name. Old name .....
[ ] The following person's Medicare number is about to expire, please renew.
[ ] The following person's Medicare number expired in the last 6 months, please renew.
[ ] The following person has 2 Medicare cards.
[ ] Please tell us the expiry date of the following person's Medicare card.
[ ] The following person passed away on .....
[ ] Other .....

NAME ..... (New name if applicable)
DOB ...../...../.....
MEDICARE NUMBER ..... Ref..... Valid to .....
2nd NUMBER (if applicable) ..... Ref..... Valid to .....

FOR BABIES ONLY - MEDICARE UNKNOWN

MOTHER'S NAME .....
MOTHER'S MEDICARE NUMBER ..... CHILD'S HRN .....

OTHER INFORMATION WHICH MAY BE RELEVANT (eg, visitor from another community)

.....

Signed: ..... Position: Medicare Trainer .....
I certify that, to the best of my knowledge, the person named on this fax is a resident of this community or is a current client of this medical service.

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