**Victorian Forensic Paediatric Medical Service**

**REGIONAL CLAIM FORM**

**(This form does not constitute a Tax Invoice - Please remit an ATO Compliant Tax Invoice with this Claim Form)**

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| --- | --- | --- | --- | --- | --- |
| **Patient Examined** | | | | **Service Code** | |
| **Surname:** |  | | | Please Tick One Service Code Only | |
| **Given Name(s):** |  | | | 🗆 | Injury evaluation |
| **Address:** |  | | | 🗆 | Sexual abuse allegation |
| **Suburb:** |  | **Post Code:** | | 🗆 | Forensic evaluation of symptom or behavior (possible abuse or neglect) |
| **DOB:** |  | 🗆 Male | 🗆 Female | 🗆 | Harm assessment (past abuse/neglect &/or evaluation of current risk or harm) |

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| --- | --- | --- |
| **Referral Details** | | |
| **Contact Name:** | **Agency:** | **Phone:** |
| **Location of Examination:** | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Service Details** | | | | | |
| **Date of Service**: |  | | **Please Use 24 Hour Clock** | | |
| **Type of Service:** | 🗆 In hours | 🗆 After hours | **Call Received**: |  | Hours |
| 🗆 Routine | 🗆 Urgent\* | **Case Commenced:** |  | Hours (your attendance for the case) |

*\*****Where a requesting agency asks for immediate attendance***

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| --- | --- | --- | --- | --- |
| **Service Fee Calculation** | | | | |
| **1. Time claimed:\*** | Total Hours Total Minutes | | | $ |
| **2. Report:** | 🗆 Simple 🗆 Routine | | | $ |
| **3. Travel:** | Total Kms Claimed @ $ per km | | | $ |
| **4. Court attendance:** |  | | | $ |
| **5. Case conference:** |  | | | $ |
| **GST Applicable (10%)** | | | | **$** |
| **TOTAL CLAIM AMOUNT** | | | | **$** |
| **Practitioner Name:** | | **Practitioner Signature:** | | |
| **IMPORTANT NOTE**: **Your fee will be paid directly to your bank account, please supply details below** | | | | |
| **BSB:** | **Account Number:** | | **Fax/Email  Notification:** | |

\* **Time claimed includes travel to/from case and the attendance for the case**

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| **PLEASE ATTACH MEDICAL REPORT, COMPLETED CLAIM FORM & TAX INVOICE AND FORWARD TO: (Form MUST be received within 30 days of consultation)**  Admin Officer, VFPMS, Royal Children’s Hospital, 50 Flemington Road, Parkville, VIC 3052  Telephone: (03) 9345 9075 Fax: (03) 9345 4105 Email: [enquiries@vfpms.org.au](mailto:enquiries@vfpms.org.au?subject=VFPMS%20enquiry) |

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| **VFPMS Use Only**  Date Received: ……………………………. UR # ………………………….. Date to Finance: …………………………….. |