



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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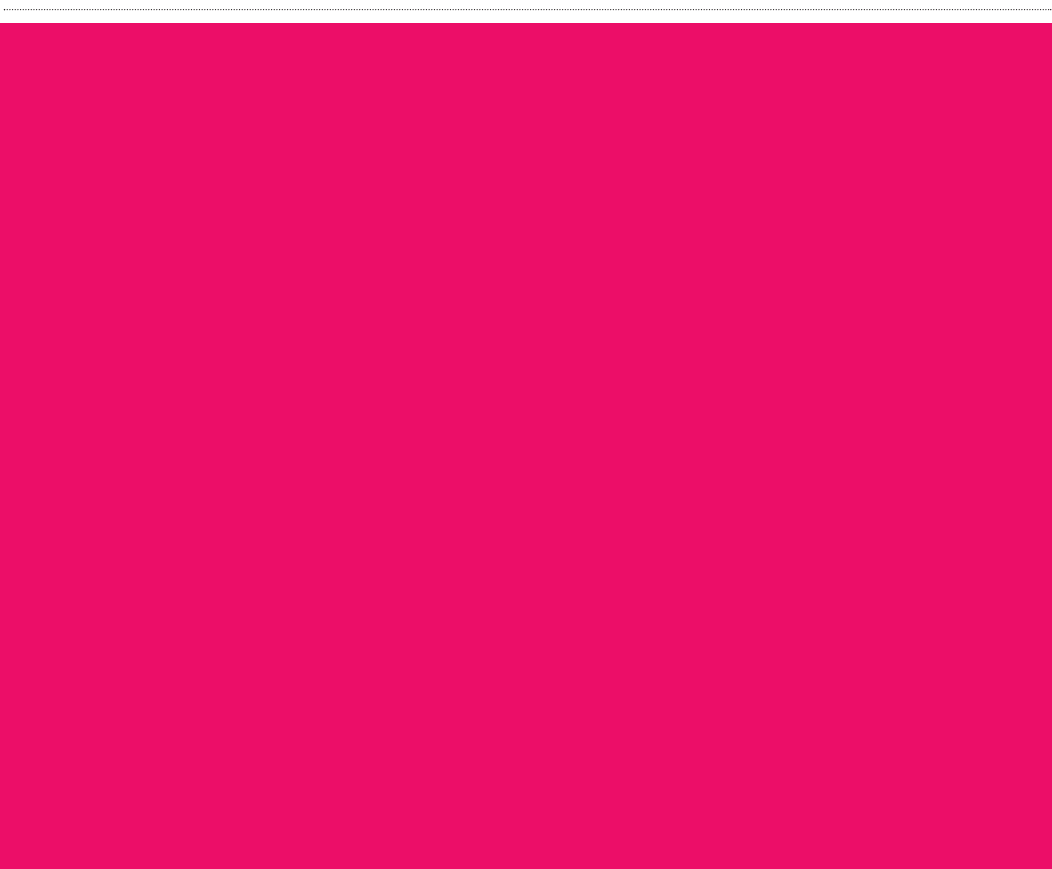
Postcode

Telephone number

Telephone number

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Doctor's name and full address



Do not write on this tinted area

In case of queries, contact:  
at: