Darwin Day Surgery

F-60 Workers Compensation Approval Form

Please complete prior to patient admission and return via the following:

Email: reception@darwindaysurgery.com.au OR Fax: **(08) 7922 2288**

Employer Details

Business Name: _____ ABN/ACN: _____

Supervisor Name: _____

Business Address: _____

Postal Address: _____

Contact Number: _____ Email: _____

Funding Details

W/Comp Insurer: _____ Policy Number: _____

Claim Number: _____

Card Number: _____ Expiry: _____ CVV: _____

Darwin Day Surgery

F-60 Workers Compensation Approval Form

Declaration

I, _____ of _____ agree to provide payment OR all Worker's Compensation details to Darwin Day Surgery for _____ prior to their admission. I am aware that I will be liable to cover any outstanding accounts associated with the procedure after this time as well as any outstanding accounts should my Insurance Provider reject or short pay my claim for any reason.

Signature: _____ Date: _____

How to Pay

To pay via MasterCard or VISA
By Phone:
08 8927 2756
By Direct Deposit:
BSB: 035 306
Account: 284 536