



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

Email: [reception@darwindaysurgery.com.au](mailto: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: \_\_\_\_\_



**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

**Medical In Confidence**

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