

Please complete in BLOCK CAPITALS and tick  as appropriate

## Patient's details

## Date if claim sent electronically

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

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

Rural practice payment. Distance in miles from patient's temporary residence to my main surgery is

*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

Name

Date

Practice stamp