NSW GOVERNMENT | Health Pathology

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CONSENT FOR PAYMENT OF NON-MBS TESTS

Patient Details

MRN (If available)

Name DOB / /

Address

Post Code

Phone Email

Requesting Practitioner

Name Provider Number

Address

Post Code

Test Requested

Test name	**Price (Inc GST)**
TOTAL	

Person/Institution Responsible for Payment

Name

Address

Post Code

Phone Email

I understand that the test requested is not covered by Medicare. I have been advised of the cost and understand that I will receive an invoice from a Pathology Provider for this service, and I accept responsibility for the full payment of the fee for the test.

Date / / Signature

For Office Use Only

Payment Received by	*Collection Site*	*Receipt No.*
Testing Location		