Fees Estimate Request

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Email Address: _____

Address: _____

Attending Doctor: _____

Principle Diagnosis: _____

Admission Date: _____ Length of Stay: _____ Procedure Length: _____

ICU/HDU/CCU Required? _____ Number of Nights: _____

Reason for Admission: _____

Provisional MBS Item Numbers: _____

Medicare Number: _____ Ref: _____ Expiry: _____ Australian Resident? ☐ Yes ☐ No

Person Responsible for the Account: ☐ Self ☐ Workcover ☐ Third Party ☐ Parent/Guardian

Parent guardian's name and contact details if different to patient: _____

Health Fund Information: _____ Membership No: _____

Consumables & Prosthetics

If not provided, pricing will be based on the similar cases performed by the attending doctor in the past 3 months.

Charge Type	Estimated Cost

Please email your completed form to **estimations@sah.org.au**

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Adventist HealthCare