

**Mental Health Compulsory Assessment & Treatment Act Claim Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| Claimants Claim Reference Number |  | Payee Number |  |

|  |  |
| --- | --- |
| Claimants Name (Please print) | Claimants Address |
|  |  |

Order made Yes / No (circle one)

FOR EXAMINING AND CERTIFYING AS TO THE MENTAL CONDITION OF:

|  |
| --- |
| (Patients Name) |

Details Summary

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Service |  |  | Examination Fee | $ |
| Time of Service  |  |  | Mileage Fee | $ |
| Mileage  |  |  | Total Claimed | $ |

**Certification: I certify that this claim is true and correct.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date\_\_\_\_\_\_\_\_\_\_

# Signature of Claimant

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date\_\_\_\_\_\_\_\_\_\_

Signature of Officer Authorised by Director Area Mental Health Services

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HealthPAC Payment Office Use Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total Fees |  |  |  | Initials | Date |
| Comp |  |  | Checked |  |  |
| Alc |  |  | Certified |  |  |
| km |  |  | Entered |  |  |
| Total Stats |  |  |  |  |  |