MINISTRY OF HEALTH
MANATŪ HAUORA

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	
Time of Service	
Mileage	

Examination Fee	$
Mileage Fee	$
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

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HealthPAC Payment Office Use Only

Total Fees	
Comp	
Alc	
km	
Total Stats	

	Initials	Date
Checked		
Certified		
Entered		

Post Claim to HealthPAC, PO Box 1026, Wellington