##

CONFIDENTIAL

**MEDICAL FEE CLAIM FORM**

|  |  |
| --- | --- |
| Section 1 – Social Worker/ Local Authority Officer/Agent to complete and send to doctorTo: Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Block Capitals Please)Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| In order to comply with the regulations or to provide the following services as indicated by Code Number \_\_\_\_\_\_\_\_\_\_\_\_\_ on the schedule overleaf, will you please examine / report / attend Case Conference (delete as applicable) on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please send your report / confirmation of attendance at Case Conference together with this claim form to: |
| Officer’s Signature Team Manager’s SignatureName of Initiating Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Block Capitals Please) | **Requestor’s Office Address Stamp** |

|  |  |
| --- | --- |
| Section 2 – Doctor to complete and return to requesting officer**CLAIM FOR FEES OR ALLOWANCES PAYABLE TO DOCTORS FOR SERVICES CARRIED OUT FOR LOCAL AUTHORITIES OR THEIR AGENTS (OTHER THAN THOSE PROVIDED UNDER THE NHS)** |  |
| I declare that I have carried out the services as indicated by Code Number \_\_\_\_\_\_\_\_\_\_\_\_ on the schedule overleaf and wish to claim a fee in accordance with the National Health Service Act 2006 |
| Signature of Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Doctor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Block Capitals Please)Please give Medical Practitioner StatusIf not General Practitioner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  **General Practitioner’s Stamp** |
| Are you an Approved Medical Practitioner under Section 12 of the Mental Health Act? Yes NoWhen claiming, please tick the appropriate box in answer to the following questions:-1. Date service given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Is the patient on your list: Yes No3. Does this claim refer to: MEDICAL EXAMINATION ONLY    REPORT ONLY OR BOTH ATTENDANCE AT CASE CONFERENCE4. Was the examination carried out at the patient’s:   HOME PRACTICE PREMISES ELSEWHERE5. Was this the patient’s: FIRST EXAMINATION SUBSEQUENT EXAMINATION 1. If you saw more than one patient, or attended a case conference, please state the duration of the session to the nearest half hour \_\_\_\_\_\_\_\_\_
2. If you wish to claim travelling expenses, please state the total mileage incurred \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Details of car used: Make \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Engine Capacity \_\_\_\_\_\_\_\_\_\_\_\_\_\_ cc   Registration No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PLEASE RETURN TO THE REQUESTING OFFCER – ADDRESS IN SECTION 1** |

|  |  |
| --- | --- |
| Section 3 – Requesting officer Team Manager to complete, sign and send to Council payment office ((CODE 01 and 02 services only) *or to practice for forwarding to CCG payment office ( all other service codes)* To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**PAYMENT OFFICE- INSERT COUNCIL / CCG DETAILS AS APPROPRIATE)** |  |
| Name of Team Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Block Capitals)Date -----------------------------------**FOR SERVICES LISTED UNDER CODES 03 TO 10 OVERLEAF LEGAL RESPONSIBILITY FOR PAYMENT RESTS WITH THE CCG HOLDING THE PRACTICE’S PRIMARY MEDICAL SERVICES CONTRACT AND NOT WITH DONCASTER COUNCIL** |

**SCHEDULE OF SERVICES PROVIDED TO DONCASTER COUNCIL OR ITS AGENTS FOR WHICH THE COUNCIL AND / OR THE NHS ARE FINANCIALLY RESPONSIBLE**

|  |
| --- |
| **The following services are the financial responsibility of Doncaster Council:****Code No** |
| **02****01** | Medical evidence given **at the request of a Court** (NOT medical reports required by the Directorate for People as evidence and/or the attendance at Court of a Doctor when this is required by the Directorate of Social Care & Health – see Item 07 below)(Will be recharged by the Council Finance Section to the Court Authorities)Medical fees for adoption purposes. |

**The following services are the financial responsibility of the NHS (CCG):**

|  |  |
| --- | --- |
| **10****09****08****04****07****06****05****03** | Initial and routine examination of children looked after by the Local AuthorityExamination of prospective foster carersConsultant Ophthalmologist’s fee for examining people with a visual disability(*criteria for payment of fee outlined on form BD8*)Assessment under Mental Health Act – examination feeReports **required by the Council** as Court evidence and /or attendance of Doctor at Court as a witness when **required by the Council**.Medical examination and report for Community Care Assessment (use form H3 for report)Attendance at Case Conference or any other relevant meeting at request of social worker.Medical Report at request of Doncaster Council **in relation to any other of its *Education,Social Services and Public Health responsibilities.*** |

|  |  |
| --- | --- |
| Section 4 – Council / CCG Payment Office to complete  **£    p****Fee payable for service:**  |  |
| **Travel: \_\_\_\_\_\_\_\_\_\_\_ Miles @ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Checked by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****TOTAL PAID:**  |

**After completion of sections 1, 2, and 3 forms should be forwarded as appropriate to the Doncaster Council Payment Office by the requesting officer/Team Manager (for Code 01 or Code 02 services only ) or to the relevant CCG by the Practice (for all other services):**