

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?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Person Responsible for the Account: <input type="checkbox"/> Self <input type="checkbox"/> Workcover <input type="checkbox"/> Third Party <input type="checkbox"/> 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 Mount.PatientEstimates@healthscope.com.au

Mount Private Hospital

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