

## POAC REFERRAL

 ${f f Z}$  Final claims should be submitted within 30 days with detailed clinical notes provided

☑ Claims exceeding \$300 (excludes Cellulitis) require pre-approval by phoning POAC (09) 535 7218

 $\ensuremath{\square}$  Other applicable funding streams (ACC, maternity, NASC) should be used in the first instance

 $\ensuremath{\square}$  POAC will fund the ACC treatment surcharge under the St John transport service or the

POAC hospital supported discharge service. Other services may be funded upon request.

## **POAC CASE NUMBER:**

O <sub>CM</sub>	<b>O</b> AK	ONW
Indicate case	number pre	fix based on
the pat	tients place	of residence

TOTAL CLAIM

## SECTION 1: Complete all details of this section and fax within 24 hrs to (09) 535 7154

iated by:	GP or A & N	vı C	St John (POA	C transport serv	vice) O Hospit	al (POAC support	ted discharge se	rvice)
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IHI				Date of l	pirth			
Ethnicity				Gender	Ома	e O Female		
Address								
Phone				Mobile				
ferring GP: GP Name				GP Signa	ture			
Practice Name				Practice	Phone			
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