Sandwell

MEDICAL FEE CLAIM FORM
CONFIDENTIAL

Sandwell NHS
Primary Care Trust

Form SS193

SECTION 1 SOCIAL WORKER TO COMPLETE

TO: Doctor: _____ (BLOCK CAPITALS)

Address: _____

_____

Please could you carry out the Following service | | |

Will you please examine/report on:

Name: _____ Date of Birth: | | | |

Address: _____

Name of Initiating officer: _____ Tel No: _____

Signature: _____ Date: | | | |

SOCIAL SERVICES ADDRESS STAMP

Family Placements
Sandwell MBC
PO Box 2374
Oldbury
West Midlands
B69 3DE

PLEASE MAKE YOUR REPORT ON THE ATTACHED FORM AND RETURN TO THE ABOVE

SECTION 2 DOCTOR TO COMPLETE

NB If you are a full-time employee of the National Health Service you are not eligible to claim. (This excludes Consultants, GP's and Section 12 Approved Doctors)

CLAIM FOR FEES AND ALLOWANCE PAYABLE TO DOCTORS FOR WORK CARRIED OUT IN THE COMMUNITY FOR MEDICAL SERVICES TO THE LOCAL AUTHORITY (UNDER THE COLLABORATIVE SERVICE ARRANGEMENTS)

I declare that I have completed the above requested service and as such, wish to claim the appropriate fee in accordance with the National Health Service Regulations.

Name of Doctor: _____ (BLOCK CAPITALS)

Signature of Doctor: _____

GP'S STAMP

Please give medical status if not a General Practitioner:

_____

Please provide details where payment should be made:

_____

Cheque Payable to: _____

Bank Details if BACS preferred: _____

MEDICAL EXAM FEE WILL BE PAID IF PREFERENCES ARE INCOMPLETE

SECTION 2 **DOCTOR TO COMPLETE CONTINUED**

Are you approved as a Certifying Officer Under Section 12(2) Of the Mental Health Act 1983? **Yes** ☐ **No** ☐

All doctors to complete following.

1. Date of Service/Assessment given: _____

   Time of Service/Assessment given: _____

1(a). Assessment for: _____

1(b). Outcome of Assessment: _____

_____

2. Is the patient on your list? **Yes** ☐ **No** ☐

3. Does the claim refer to: **Medical Examination Only** ☐

   Medical Examination and Report ☐

4. Was the examination carried out at: **Patients Home** ☐

   Elsewhere ☐

   If elsewhere, please state: _____

   _____

5. Was this the patient's: **First Examination** ☐

   Subsequent Examination ☐

6. If you saw more than one patient or attended a case conference, please state the duration of the session:

   _____

7. **If you wish to claim travelling allowance, please state:**

   Total Mileage incurred: _____

   Make of Car: _____

   Registration No: _____

   Engine Capacity: _____

Please ensure that all sections are completed – <u>NO</u> claims will be passed for payment if any sections are left incomplete.

SECTION 3	TEAM MANAGER TO COMPLETE

To:	Primary Care Trust Payments Office

I confirm that the above requested work has been completed.

SOCIAL SERVICES AUTHORISATION STAMP

Family Placements
Sandwell MBC
PO Box 2374
Oldbury
West Midlands
B69 3DE

Name of Team Manager: _____
(BLOCK CAPITALS)

Signature: _____

Signature Number: | | | | - | | |

Date: | | | |

SECTION 4	PAYMENT OFFICE ONLY

Fee Payable: _____ Checked by: _____ Date: _____
(Consultant in Public Health Medicine)

Travel _____ Miles @ _____

Total Paid _____

Passed for Payment by: _____

Please send completed forms to:

Mrs K Bonehill
Sandwell Primary Care Trust
438 High Street
West Bromwich
West Midlands
B70 9LD

CODE	SERVICE REQUIRED
00	Psychiatric Examination – Consultant or Specialist. Work carried out by **Approved** Practitioner under Section 12 (2) Of the Mental Health Act 1983
01	Psychiatric Examination – Carried out by Practitioner **NOT Approved** under section 12 (2) of the Mental Health Act 1983
02	Examination of Blind or Partially sighted person for CV1 Form **First Examination** to take place in consulting room
03	Examination of Blind or Partially sighted person for CV1 Form **Second Examination** to take place in consulting room
04	Examination of Blind or Partially sighted person for CV1 Form **First Examination** to take place in patient/s home (Domiciliary)
05	Examination of Blind or Partially sighted person for CV1 Form **Second Examination** to take place in patient/s home (Domiciliary)
06	Child/children in Care, Adoption and Fostering, Examination and Report on Child – **First Examination**
07	Child/children in Care, Adoption and Fostering, Examination and Report on Child – **Subsequent Examination**
08	Child/Children in Care, Adoption and Fostering, Admission examination for issue of Report
09	Examination and Report for Adoption and Fostering, Medical History Report on Children **over 5 years** (Paediatric)
10	Examination and Report for Adoption and Fostering, Medical History Report on Children **under 5 years** (Obstetric or Neonatal)
11	Prospective Adoptive Parent
12	Updated Prospective Adoptive Parent
13	Prospective Foster Parent
14	Case Conference Carried out by person of **Consultant Status** – to include child abuse
15	Case Conference Carried out by person of **General Practitioner Status** – to include child abuse
16	Court Attendance by **Consultant** (payment will only be made when service has received prior agreement with Sandwell PCT.)
17	Court Attendance by **General Practitioner** (payment will only be made when service has received prior agreement with Sandwell PCT.)
18	Disabled Persons Parking Badge (Examination and Opinion)
19	Telephone or Piper Lifeline

CONSULTANT FEE PAYABLE FOR CV1 REFERRAL *(please ensure that both SS193 and CV1 are enclosed when sending to PCT for payment)*

NOTE: ***These codes represent only those items which should be paid under the Collaborative Services Arrangement. Any other service required which does not appear on the listing above will NOT be payable by Sandwell PCT.***