|  |  |  |
| --- | --- | --- |
| Mileage |  |  |
| **Post Code** | **Post Code** |  |
|   |   |  |
|   |   |  |
| **Total Mileage** |   |  |
| **Engine Size** |   |  |



Kent County Council Kent Adult Social Services Department

SS.196

**PAYMENT OF FEES TO MEDICAL PRACTITIONERS**

To: Collaborative Claims Team

---------------------------------------------------------- CLINICAL COMMISSING GROUP

The Medical Practitioner named below attended at the location given for the reason stated.

Name of Medical Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Block Capitals)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NHS Number: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date and Time of examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of AMHP: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kent AMHP Service**

**Invicta House, County Hall, Sandling Road, Maidstone, ME14 1XX**

**Brook House, Reeves Way, Whitstable, Kent, CT5 3SS**

Tel: 03000 422480

Certified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once complete please send the hard copy or email to: (ensure you have a scanned copy for own reference)
Kent Collaborative Claims/NCA
**NEL Commissioning Support Unit**

3rd Floor, 1 Lower Marsh
London SE1 7NT

SECSU.KentCollaborativeClaims@nhs.net together with a copy of your S12 approval documentation and the attached bank details form

**BANK DETAILS FORM**

This form must be completed by all Companies claiming payment for services

PRIVATE & CONFIDENTIAL

Full Name: ….…………………………………………………………

*Address:* ...…………………………………………………………………..

 ...…………………………………………………………………..

Postcode ...…………………………………………………………………..

Phone ..…………………………………………………………………...

e-mail address …………………………………………………………………….

Remittance advice e-mail address …………………………..……………………………

(if different to above)

*Name of Bank:* ...…………………………………………………………………..

*Address of Branch:*...…………………………………………………………………..

 ...…………………………………………………………………..

 ...…………………………………………………………………..

*Bank Sort Code:*

*Account Holders Name:* ...…………………………………………………………..

*Account Number:*

**I confirm that all payments made to THE COMPANY should be credited to THE bank account as detailed above**

*Signed:* ……………………………………………………..

*Date:* ……………………………………………………..