



MINISTRY OF  
HEALTH

MANATŪ HAUORA

**Mental Health Compulsory Assessment & Treatment Act Claim Summary**

Claimants Claim Reference Number		Payee Number	
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Claimants Name (Please print)	Claimants Address

Order made Yes / No (circle one)

FOR EXAMINING AND CERTIFYING AS TO THE MENTAL CONDITION OF:

(Patients Name)
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Details Summary

Date of Service	
Time of Service	
Mileage	

Examination Fee	\$
Mileage Fee	\$
Total Claimed	\$

**Certification: I certify that this claim is true and correct.**

\_\_\_\_\_  
Signature of Claimant

Date\_\_\_\_\_

\_\_\_\_\_  
Signature of Officer Authorised by Director Area Mental Health Services

Date\_\_\_\_\_

**HealthPAC Payment Office Use Only**

Total Fees	
Comp	
Alc	
km	
Total Stats	

	Initials	Date
Checked		
Certified		
Entered		