Maternity and Infant Care Scheme Registration Form

PATIENT DETAILS

*PPSN *Date of Birth DD/MM/YYYY

**Client Identifier

*Client Name

*Address

PRACTITIONER DETAILS

*GMS Number *MCRN

*GP Name

*GP Stamp

Registration Details

*Number of Previous Births

*Expected Delivery Date

DD/MM/YYYY

*Phone Number

If you provide your mobile phone number we may text you in connection with your registration

Data Protection

☐ *The Patient has been informed that their details will be submitted as part of the Reimbursement Application Process

Doctor Acknowledgement

☐ *I undertake to provide medical and surgical services for
(a) the person named above
(b) the infant
in accordance with the conditions laid down in the Agreement made between myself and Health Service Executive for the provision of services under Section 62 & 63 of the Health Act. 1970

Declaration of Residency

☐ *I am satisfied to the best of my knowledge the above patient has been living here for a minimum of one year or intends to live here for a minimum of one year

Patient Consent

☐ *I give my consent for a doctor representing the HSE to inspect my clinical records relating to claims presented by my GP under the Maternity & Infant Care Scheme

*Patient Signature

*GP Signature

* Mandatory fields
** Client Identifier you wish to check (include client code letter for Medical Card, GP Visit Card, Drug Payment Scheme card identifiers). At least one client identifier required for payment i.e. PPSN or one of the above