Australian Government
Department of Human Services

medicare

Banking Details Online Claiming

Purpose of this form

Use this form to provide your banking details to the Australian Government Department of Human Services (Human Services) for online claiming.

Any provider not yet registered for online claiming will need to complete the ***Online Claiming Provider Agreement*** form (**HW027**). To access the agreement go to **humanservices.gov.au/healthprofessionals > Doing business with Medicare > Online business > Register**

For more information

For more information about online claiming go to **humanservices.gov.au/healthprofessionals** and search for **Register for online business** or call **1800 700 199** Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

Note: Call charges apply from mobile phones.

Filling in this form

- **Please use black or blue pen**
- Print in BLOCK LETTERS
- Mark boxes like this ☐ with a ✓ or ✗

Returning your form

Send completed form to:

Department of Human Services
The Manager
eBusiness Service Centre
GPO Box 9822
In your capital city

or

scan and email: **ebusiness@humanservices.gov.au**

or

fax:

NSW/ACT	**02 9895 3190**	QLD	**07 3004 5526**
VIC/TAS	**03 9605 7981**	WA/SA/NT	**08 9214 8173**

Privacy notice

Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at **humanservices.gov.au/privacy** or by requesting a copy from the department.

Location identifier

This form should only be completed by the payee provider of the practice. If you are the payee provider for more than 1 location, you must complete a separate form for each practice location ID (minor ID).

1 Location ID (minor ID)

Practice details

2 Practice name

3 Practice address

Postcode

Postal address (if different to above)

Postcode

4 Practice contact name

5 Daytime phone number

( )

Fax number

( )

Email

@

Corporate details

6 If your practice is part of a corporate group with 2 or more practices, please provide corporate details.

Banner group name

Corporate name

Corporate address

Postcode

7 Corporate contact name

8 Daytime phone number

( )

Fax number

( )

Email

@

Bank account details

All payments are made through Electronic Funds Transfer (EFT).

9 The following account details are to be used for the providers listed below, effective from

/ /

Name of bank, building society or credit union

Branch where the account is held

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

10 What type of online transactions do you want paid to this account?

Tick ALL that apply

Medicare Bulk Bill/Department of Veterans' Affairs claims ☐

Australian Childhood Immunisation Register claims ☐

Payee provider details

11 I undertake to immediately notify my Pay Group(s) or Third Party payee(s) of any current and/or future Notice(s) issued on Human Services to garnish or intercept payments due to me or my provider number(s).

Provider 1

Medicare provider number

Provider's full name

Provider's signature

Provider 2

Medicare provider number

Provider's full name

Provider's signature

Provider 3

Medicare provider number

Provider's full name

Provider's signature

Provider 4

Medicare provider number

Provider's full name

Provider's signature

Provider 5

Medicare provider number

Provider's full name

Provider's signature

Provider 6

Medicare provider number

Provider's full name

Provider's signature

Reset form Print form