

medicare

Bank account details for Online Claiming

Purpose of this form

Use this form to provide your bank account details to the Australian Government Department of Human Services for online claiming as a payee provider for one or more servicing providers.

Any provider not yet registered for online claiming will need to complete the *Online Claiming Provider Agreement* form (HW027). You can download a copy of this form at humanservices.gov.au/hpforms

- Please use black or blue pen
- Print in BLOCK LETTERS

Returning your form

Scan and email the completed form to: provider.forms@humanservices.gov.au

or

Fax: 1300 505 866

For more information

Go to **humanservices.gov.au/healthprofessionals** or call **1800 700 199** Monday to Friday, between 8.00 am and 5.00 pm (local time).

Note: Call charges may apply.

Location ID (minor ID)

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).

Prac	tice address				
				Postcode	!
Post	al address (it	different	to above)		

4	Practice contact name
5	Practice daytime phone number
	()
	Fax number
	()
	Email
	@
Co	rporate details
If v	your practice is part of a corporate group with 2 or more
	actices, provide corporate details.
6	Banner group name
	<u> </u>
7	Corporate name
-	
8	Corporate address
Ū	
	Postcode
9	Corporate contact name
10	Business phone number
	Fax number
	()
	Email
	@

Bank account details

Provider number All payments are made through Electronic Funds Transfer (EFT) and cannot be made into credit card, loan or mortgage accounts. Provider's full name 11 The following account details are to be used for the providers listed below, effective from Provider's signature Name of bank, building society or credit union Provider 2 Branch where the account is held Provider number Branch number (BSB) Provider's full name Provider's signature Account number (this may not be the card number) Ø1 Account held in the name(s) of Provider 3 Provider number 12 If you use Medicare Easyclaim, provide the name of the financial Provider's full name institution that supplied your Medicare Easyclaim EFTPOS terminal. Provider's signature **13** What type of online transactions do you want paid to this account? Ø1 **Tick ALL that apply** Medicare bulk bill/Department of Veterans' Affairs claims Provider 4 Australian Immunisation Register claims Provider number **Privacy notice** Provider's full name **14** 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 Provider's signature administration of payments and services. This information is required to process your application or claim. Ø1 Your information may be used by the department, or given to Provider 5 other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of Provider number research or conducting investigations). You can get more information about the way in which the Provider's full name department will manage your personal information, including our privacy policy, at humanservices.gov.au/privacy

Provider 1

Payee provider(s) declaration

15 I/We declare that:

the information I/we have provided in this form is complete and correct.

I/We understand that:

giving false or misleading information is a serious offence.

I/We undertake to:

immediately notify my pay group(s) and third party payee(s) of any current and/or future Notice(s) issued on behalf of the Australian Government Department of Human provider number(s).

Provider's signature

Provider number

Provider's full name

Provider's signature

Ø1

Provider 6