Australian Government
Department of Human Services

medicare

# Provider registration for Electronic Funds Transfer payments

## Purpose of this form

Use this form to nominate bank account details you would like the Australian Government Department of Human Services to record for 1 or more of your current Medicare provider numbers. You will need to provide your Medicare provider number to identify the practice location.

The bank account details you nominate, or any completed additional practice location bank account details, will be stored and used for all future Department of Human Services and Department of Veterans' Affairs payments payable to you.

These details will override any previous instructions given to us on where to direct your Department of Human Services and Department of Veterans' Affairs payments for the specified provider number(s) for the location(s) where you practice.

Additionally, the bank account details nominated on this form may be stored and used for future payments payable to you for other programs administered by the Department of Human Services.

For security or clarification purposes, we may contact you about your details.

## Filling in this form

- **Please use black or blue pen**
- Print in BLOCK LETTERS
- Mark boxes like this ☐ with a ✓ or ✗
- Where you see a box like this ☐ ***Go to 5*** skip to the question number shown. You do not need to answer the questions in between.

## Returning your form

Check that all required questions are answered and that the form is signed and dated.

Send the completed form to:

**Department of Human Services**
**The Manager**
**Medicare Provider Services**
**GPO Box 9822**
**MELBOURNE VIC 3000**

**or**

Scan and email to: **provider.forms@humanservices.gov.au**

**or**

Fax: **1300 505 866**

## For more information

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

**Note**: Call charges may apply.

## Provider and practice location details

**1** Medicare provider number

**2** Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

**3** Address

Postcode

**4** Daytime phone number

( )

Mobile phone number

Fax number

( )

Email

@

**5** Practice name

**6** Authorised contact person's name

The authorised contact person is someone who is authorised, on behalf of the provider named in this form, to contact us **ONLY** for enquiries.

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

**7** Authorised contact person's daytime phone number

( )

**8** Indicate the claiming method(s) used at this practice

Manual ☐ Medicare Online ☐ Medicare Easyclaim ☐

Medicare Online Minor ID (if applicable)

Medicare Easyclaim EFTPOS provider (if applicable)

**9** Is this location an Aboriginal or Torres Strait Islander health service?

No ☐

Yes ☐

## Bank account details

All payments are made through Electronic Funds Transfer (EFT) and **cannot** be made into credit card, loan or mortgage accounts.

**10** 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

**11** Would you like payments for Australian Immunisation Register Online services made to this account?

No ☐

Yes ☐

If you claim manually for the Australian Immunisation Register and you need to change your bank details, please complete the ***Australian Immunisation Register Bank account details for vaccination providers*** form **(IM005)**.

**12** Do you need to register a second practice location for EFT payments?

No ☐ ***Go to 18***

Yes ☐

## Practice location 2 details

**13** Provide details for practice location 2

Medicare provider number

Address

Postcode

Indicate the claiming method(s) used at this practice

Manual ☐ Medicare Online ☐ Medicare Easyclaim ☐

Medicare Online Minor ID (if applicable)

Medicare Easyclaim EFTPOS provider (if applicable)

Is this location an Aboriginal or Torres Strait Islander health service?

No ☐ Yes ☐

## Practice location 2 bank account details

**14** Provide bank account details for practice location 2

Are the bank account details for the provider number listed at practice location 2 identified in question 10?

No ☐ Complete bank account details below for the additional provider number.

Yes ☐ The bank account details in question 10 will be recorded for the additional provider number. ***Go to 15***

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

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

Would you like payments for Australian Immunisation Register services made to this account?

No ☐ Yes ☐

**15** Do you need to register a third practice location for EFT payments?

No ☐ ***Go to 18***

Yes ☐

## Practice location 3 details

**16** Provide details for practice location 3

Medicare provider number

Address

Postcode

Indicate the claiming method(s) used at this practice

Manual ☐ Medicare Online ☐ Medicare Easyclaim ☐

Medicare Online Minor ID (if applicable)

Medicare Easyclaim EFTPOS provider (if applicable)

Is this location an Aboriginal or Torres Strait Islander health service?

No ☐ Yes ☐

## Practice location 3 bank account details

**17** Provide bank account details for practice location 3

Are the bank account details for the provider number listed at practice location 3 identified in question 10?

No ☐ Complete bank account details below for the additional provider number.

Yes ☐ The bank account details in question 10 will be recorded for the additional provider number. ***Go to 18***

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

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

Would you like payments for Australian Immunisation Register services made to this account?

No ☐ Yes ☐

If you have more than 3 practice locations, attach copies of page 3 of this form, with their details.

**18** Indicate the total number of pages you are submitting, including this page.

## Privacy notice

**19** 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 where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

You can get more information about the way in which the department will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy**

## Declaration

**20** **I declare that**:

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

**I acknowledge that**:

- payment(s) related to my provider number(s) for the location(s) where I practice as identified on this form, including any additional practice locations attached to this form, will be paid to the bank account details I have nominated
- the Australian Government Department of Human Services may contact me to confirm these details for security or clarification purposes.

**I undertake to**:

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

**I understand that**:

- giving false or misleading information is a serious offence.

Provider's full name

Provider's signature

Date / /

Reset form Print form