Australian Government
Services Australia

medicare

Bank account details for Online Claiming (HW052)

When to use this form

Use this form to provide your bank account details to Services Australia 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 (HW027)** form. You can download a copy of this form at **servicesaustralia.gov.au/hpforms**

For more information

Go to **servicesaustralia.gov.au/healthprofessionals** or call **1800 700 199** Monday to Friday, 8 am to 5 pm (local time).

Call charges may apply.

Returning this form

Return the completed form:

- **by email** to: **provider.forms@servicesaustralia.gov.au** There may be risks with sending personal information through unsecured networks or email channels.
- by fax to: **1300 505 866**

Filling in this form

You can complete this form on your computer, print and sign it.

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this ☐ ***Go to 1*** skip to the question number shown.

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 Minor ID (location ID).

1 Minor ID (location ID)

Australian Immunisation Register

2 Do you want to register your software to transact with the Australian Immunisation Register?

No ☐ ***Go to 4***

Yes ☐

3 Is this an additional software product that you wish to register? (for example, additional to a Medicare/PBS software product)

No ☐

Yes ☐

Practice details

4 Practice name

5 Practice address

Postcode

Postal address (if different to above)

Postcode

6 Practice contact name

7 Practice daytime phone number

Fax number

( )

Email

Corporate details

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

8 Banner group name

9 Corporate name

10 Corporate address

Postcode

11 Corporate contact name

12 Business phone number

Fax number

( )

Email

Financial institution details

The bank, building society or credit union account must be in your name. A joint account is acceptable. Payments cannot be made to credit card, loan or mortgage accounts.

Payments cannot be made to an account used exclusively for funding from the National Disability Insurance Scheme.

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

/ /

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

14 If you use Medicare Easyclaim, provide the name of the financial institution that supplied your Medicare Easyclaim EFTPOS terminal.

15 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 Immunisation Register claims ☐

Privacy notice

16 Your privacy and security of your personal information is important to us, and is protected by law. We collect this information to provide payments and services. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacy**

Payee provider(s) declaration

17 **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 Services Australia to garnish or intercept payments due to me or my provider number(s).

Provider 1

Provider number

Provider's full name

Provider's signature

On completion, print and sign by hand.

Provider 2

Provider number

Provider's full name

Provider's signature

On completion, print and sign by hand.

Provider 3

Provider number

Provider's full name

Provider's signature

On completion, print and sign by hand.

Provider 4

Provider number

Provider's full name

Provider's signature

On completion, print and sign by hand.

Provider 5

Provider number

Provider's full name

Provider's signature

On completion, print and sign by hand.

Provider 6

Provider number

Provider's full name

Provider's signature

On completion, print and sign by hand.

Reset form Print form