

medicare

When to use this form

Use this form to nominate bank account details you would like Services Australia 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 Services Australia and Department of Veterans' Affairs payments payable to you.

These details will override any previous instructions given to us on where to direct your Services Australia 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 Services Australia.

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

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.

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.

Provider and practice location details

or	
Other vaccinati	ion provider number (AIR only)
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	Mrs Miss Ms Other
Dr 🗌 Mr 🗌	INIS INISS INS UTHER
	I MITS I MISS I MIS UTHER
	i mirs miss mis other
Dr Mr Family name First given nam	

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Practice					
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8	Indicate the claiming method(s) used at this practice	Prac	tice location 2 details
	Manual 🦳 Medicare Online 🗌 Medicare Easyclaim 🗌	12 1	Provide details for practice location 2
	Australian Immunisation Register	IJ I	
	Minor ID (location ID) if applicable		Medicare provider number
	Mediene Feruelaire FFTDOC gravider (if eachighte)		or
	Medicare Easyclaim EFTPOS provider (if applicable)		Other vaccination provider number (AIR only)
	Australian Immunisation Register (if applicable)		Address
	Do you want to register your software to transact with the		
	Australian Immunisation Register?		
	No		
	Yes 🕩 Is this an additional software product that you wish to		Postcode
	register? (for example, additional to a Medicare/PBS		Indicate the claiming method(s) used at this practice
	software product)		Manual Medicare Online Medicare Easyclaim
	No Yes		Australian Immunisation Register
9	Is this location an Aboriginal or Torres Strait Islander health		Minor ID (location ID) if applicable
	service?		
	No		
	Yes		Medicare Easyclaim EFTPOS provider (if applicable)
Pa	nk account details		Australian Immunication Degister (if applicable)
Da			Australian Immunisation Register (if applicable) Do you want to register your software to transact with the
A	I payments are made through Electronic Funds Transfer (EFT)		Australian Immunisation Register?
ar	nd cannot be made into credit card, loan or mortgage accounts.		No
10	Manage of the set of t		Yes I is this an additional software product that you
10	Name of bank, building society or credit union		wish to register? (for example, additional to a
			Medicare/PBS software product)
	Branch number (BSB)		No Yes
			Is this location an Aboriginal or Torres Strait Islander health
			service?
	Account number (this may not be the card number)		No Yes
	Account hold in the name(a) of		
	Account held in the name(s) of	Prac	tice 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
11	Would you like payments for Australian Immunisation Register		practice location 2 identified in question 10?
	Online services made to this account?		No Decomplete bank account details below for the additional provider number.
			Yes The bank account details in question 10 will be
	Yes		recorded for the additional provider number. <i>Go to 15</i>
	If you claim manually for the Australian Immunisation Register and you need to change your bank details, please complete		All payments are made through EFT.
	the Australian Immunisation Register Bank account		Name of bank, building society or credit union
	details for vaccination providers (IM005) form.		
12	Do you need to register a second practice location for EFT		
	payments?		Branch number (BSB)
	No 🕒 Go to 18		Account number (this may not be the card number)
	Yes		
			Account held in the name(s) of
			Would you like payments for Australian Immunisation Register services made to this account?

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

No **Go to 18** Yes

Practice location 3 details

Medicare	provider number
or	
	cination provider number (AIR only)
Address	
Auuress	
	Postcode
Indicate t	he claiming method(s) used at this practice
Manual	Medicare Online Medicare Easyclaim
Australiar	n Immunisation Register 🗌
Minor ID	(location ID) if applicable
Medicare	Easyclaim EFTPOS provider (if applicable)
Medicare	Easyclaim EFTPOS provider (if applicable)
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Australiar Do you w Australiar No Yes Yes	 Immunisation Register (if applicable) ant to register your software to transact with the Immunisation Register? Is this an additional software product that you wish to register? (for example, additional to a Medicare/PBS software product)

Practice location 3 bank account details

	bank account details for the provider number liste 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			
All pay	ments are made through EFT.			
Name of	f 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			
Would v	ou like payments for Australian Immunisation Reg			
	made to this account?			
No	Yes			

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

Privacy notice

19 The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. 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**

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
- Services Australia 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 Services Australia 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

Drouidar'a	aiapatura
Provider's	signature

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Date

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Returning this form

Return this form and any supporting documents:

- by post to: Services Australia The Manager Medicare Provider Services GPO Box 9822 MELBOURNE VIC 3000
- 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