Australian Government
Services Australia

medicare

Provider registration for Electronic Funds Transfer payments (HW029)

When to use this form

Use this form to nominate bank account details you would like Services Australia to record for one 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).

Filling in this form

You can fill this form digitally in some browsers, or you can open it in Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader, you can print this form and complete 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

1 Medicare provider number

or

Other vaccination provider number (AIR only)

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

Family name

First given name

3 Address

Postcode

4 Daytime phone number (including area code)

Mobile phone number

Fax number (including area code)

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 ☐ Mx ☐ Other

Family name

First given name

7 Authorised contact person's daytime phone number (including area code)

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

Manual ☐ Medicare Online ☐ Medicare Easyclaim ☐

Australian Immunisation Register ☐

Minor ID (location ID) if applicable

Medicare Easyclaim EFTPOS provider (if applicable)

Australian Immunisation Register (if applicable)

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 register? (for example, additional to a Medicare/PBS software product)

No ☐ Yes ☐

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 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 (IM005)** form.

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

or

Other vaccination provider number (AIR only)

Address

Postcode

Indicate the claiming method(s) used at this practice

Manual ☐ Medicare Online ☐ Medicare Easyclaim ☐

Australian Immunisation Register ☐

Minor ID (location ID) if applicable

Medicare Easyclaim EFTPOS provider (if applicable)

Australian Immunisation Register (if applicable)

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 register? (for example, additional to a Medicare/PBS software product)

No ☐ Yes ☐

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 EFT.

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

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

or

Other vaccination provider number (AIR only)

Address

Postcode

Indicate the claiming method(s) used at this practice

Manual ☐ Medicare Online ☐ Medicare Easyclaim ☐

Australian Immunisation Register ☐

Minor ID (location ID) if applicable

Medicare Easyclaim EFTPOS provider (if applicable)

Australian Immunisation Register (if applicable)

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 register? (for example, additional to a Medicare/PBS software product)

No ☐ Yes ☐

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 EFT.

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

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

No ☐ Yes ☐

If you have more than 3 practice locations, provide 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 The privacy and security of your personal information is important to us, and is protected by law. We 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/privacypolicy**

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

Provider's signature

On completion, print and sign by hand.

Date (DD MM YYYY)

Returning this form

Return this form and any supporting documents by:

- **email** to **provider.forms@servicesaustralia.gov.au**
  There may be risks with sending personal information through unsecured networks or email channels.
- post to

  Services Australia
  The Manager
  Medicare Provider Services
  GPO Box 9822
  MELBOURNE VIC 3000
- fax to 1300 505 866

Reset form