

# Practice Nurse Incentive Program Change of Practice Details

## Important information

Complete this form to notify the Department of Human Services of a change of ownership, a relocation, an amalgamation, a change of bank details, a withdrawal or a change of authorised contact person(s) for the Practice Nurse Incentive Program (PNIP).

For a practice to change their bank account details only, they need to complete the Current Practice Details section, tick the appropriate Notification Type and complete question 31. The authorised contact person or the practice owner is required to sign the form in the Declaration section.

Do not complete questions 1 to 4 if your practice is not relocating, amalgamating or changing ownership.

## Assistance

For more information about the PNIP go to [medicareaustralia.gov.au/pnip](http://medicareaustralia.gov.au/pnip) or email [pnip@humanservices.gov.au](mailto:pnip@humanservices.gov.au). If you need assistance completing this form call the PNIP on **1800 222 032** (call charges apply) between 8.30 am and 5.00 pm, Monday to Friday, Australian Central Standard Time.

## Lodgement

Send the completed form to:

**Practice Nurse Incentive Program  
GPO Box 2572  
ADELAIDE SA 5001**

or fax to: **1300 587 696**

Print in **BLOCK LETTERS**

Tick where applicable

## Eligibility requirements

The following questions indicate if the practice is eligible for the PNIP.

**1** Does your practice have current public liability insurance?  
No  *Your practice is not eligible to participate in the PNIP*  
Yes

**2** Do all practice General Practitioner's (GP's) have current professional indemnity cover?  
No  *Your practice is not eligible to participate in the PNIP*  
Yes

It is an entry requirement of the PNIP that the practice is accredited or registered for accreditation. If you answer NO to both questions 3 and 4, your practice may be eligible for grandparenting only.

**3** Is your practice currently accredited?  
No   
Yes  *Provide evidence  
(e.g. a copy of your accreditation certificate)*

**4** Is your practice registered for accreditation?  
No   
Yes  *Provide evidence  
(e.g. a copy of your registered for accreditation certificate)*

## Current practice details

The following information fields are to be completed with the current practice details.

**5** Practice ID

**6** Practice name

**7** Address  
  
  
  
Postcode

**8** Postal address (if different from above)  
  
  
Postcode

**9** Daytime phone number

Fax number  
( )

Email  
  
@

## Notification type

**10** Tick the relevant box(es) that apply to your practice

- Relocation  **Go to 11**  
Amalgamation  **Go to 18**  
Change of ownership  **Go to 24**  
Bank details  **Go to 31**  
Authorised contact person details  **Go to 32**  
Withdrawal  **Go to 33**

## Relocation details

Complete this section if the practice is moving to a new location.

**The following questions are to be completed with the new practice information.**

An Individual General Practitioner Details form is to be completed by all GP's at the relocated practice.

**11** Date of relocation

**12** Practice Name

**13** Address

---

---

---

Postcode

**14** Postal address (if different from above)

---

---

Postcode

**15** Phone number

Fax number

Email

---

---

@

**16** Have the owners of the practice retained ownership of the relocated practice?

No  *You will need to complete the change of ownership details section. Go to 24*

Yes

Complete the Individual GP details at questions 30 for any GP's no longer working at the practice as a result of a relocation.

**17** Is the old location still operating as a general practice, Aboriginal Medical Service and/or Aboriginal Community Controlled Health Service?

No

Yes  *Contact the PNIP on 1800 222 032*

## Amalgamation details

Complete this section if the existing PNIP practice is amalgamating with another practice or other practices

**The following questions are to be completed with the new practice information**

An Individual General Practitioner Details form is to be completed by each new GP at the practice.

**18** Date of amalgamation

**19** Practice ID numbers involved in the amalgamation

**20** Practice name

**21** Address

---

---

---

Postcode

**22** Postal address (if different from above)

---

---

Postcode

**23** Phone number

Fax number

Email

---

---

@



Attach documentary evidence to confirm the practice amalgamation. Contact the PNIP on 1800 222 032 if you require assistance.

Complete the GP details at question 30 for any GP's no longer working at the practice as a result of an amalgamation.

## Change of ownership details

Complete this section if the practice has undergone a change of ownership. All new owners will need to sign the declaration.



Attach documentary evidence to confirm the change of ownership (e.g. a bill of sale or legal document)

**24** Date ownership changed

**25** Indicate the type of practice ownership arrangement that applies:

**Individual proprietor**

Application to be completed by the proprietor

**Partnership**

Application to be completed by the partners of the practice  
Obtain all partners signatures

**Associateship**

Application to be completed by all associates who are owners of the practice

Do not include the signatures of practice associates who are not owners of the practice

**Body corporate**

Application to be completed by at least two authorised representatives of the corporation (eg: company director and company secretary)

**State or Territory Government or other public body**

Application to be completed by an authorised representative of the practice

**26** Company name

**27** Trading as

**28** List all the new practice owners in the space provided.  
If the person has an individual Public Key Infrastructure (PKI) certificate, you should provide the Registration Authority (RA) number in the space provided.

The RA number is located on the tag attached to the PKI Universal Serial Bus Key (USB), or on the card sent with the USB card reader.

The RA number will be used to allow access to the PNIP online.

**Individual/Partner/Associate/Authorised Representative one**

Full name
<input type="text"/>
Position held
<input type="text"/>
RA number (if applicable)
<input type="text"/>

**Individual/Partner/Associate/Authorised Representative two**

Full name
<input type="text"/>
Position held
<input type="text"/>
RA number (if applicable)
<input type="text"/>

**Individual/Partner/Associate/Authorised Representative three**

Full name
<input type="text"/>
Position held
<input type="text"/>
RA number (if applicable)
<input type="text"/>

**Individual/Partner/Associate/Authorised Representative four**

Full name
<input type="text"/>
Position held
<input type="text"/>
RA number (if applicable)
<input type="text"/>

**Individual/Partner/Associate/Authorised Representative five**

Full name
<input type="text"/>
Position held
<input type="text"/>
RA number (if applicable)
<input type="text"/>



Attach a separate sheet with details if there is insufficient space.

**29** Was the accreditation included in the sale of the practice?

No  **Contact the PNIP on 1800 222 032**

Yes

## General practitioner details

If there have been changes to your practices arrangements, attach a completed Individual General Practitioner Details form for each GP at the practice/location.

- 30** List all General Practitioner's who have ceased working at the practice as a result of the change to the practice arrangements.

### General practitioner details one

Provider number

Full name

Date ceased working at the practice

### General practitioner details two

Provider number

Full name

Date ceased working at the practice

### General practitioner details three

Provider number

Full name

Date ceased working at the practice



If you have more than three GP's attach separate sheet with details.

## Bank account details

Payments cannot be paid into credit card, loan or mortgage accounts.

- 31** Have the bank account details for the practice changed?

No  **Go to 32**

Yes  *Provide details below*

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

## Authorised contact person details

Complete this question if the authorised contact person for the practice has changed.

- 32** Do you wish to add or remove an authorised contact person to the new practice location?

No

Yes  *Provide details below*

Authorised contact person's full name

Authorised contact persons signature

RA number (if applicable)

Add

Remove



If you have more than one authorised contact person to change attach a separate sheet with details.

## Practice withdrawal

For practice closures, complete the PNIP practice branch closure form

- 33** I am currently participating in the PNIP but would like to withdraw my practice from the PNIP?

No

Yes

## Declaration

If the practice elects to change its bank account details only, the authorised contact person or a practice owner is required to sign below.

If a change of ownership has occurred, all new owners are required to sign in the space provided.

If a change to the authorised contact persons has occurred a practice owner is required to sign below.

If a practice withdraws for Practice Nurse Incentive Program (PNIP), all practice owners must sign the declaration.

### 34 I consent to:

- advise the Department of Human Services in writing of any changes to practice arrangements by the relevant 'point in time' date or within 14 calendar days, whichever date is earliest.

### I understand that:

- the Department of Human Services may conduct compliance audits of a practice's compliance with the PNIP eligibility requirements for PNIP payments, and the practice may be required to provide information as evidence of compliance with the PNIP entry requirements and that failure to do so may result in past PNIP payments being recovered and/or future payments being suspended or ceased
- I/we may be required to provide information to the Department of Human Services as evidence of the practice's compliance with the PNIP eligibility requirements for PNIP payments

- Giving false or misleading information is a serious offence, and
- If I/we do not notify the Department of Human Services of changes, incentive payments for the PNIP may be reduced or recovered, and the practice's eligibility for the PNIP may be affected.

**I declare that:**

- I have reviewed the PNIP guidelines, and
- The information on this form is correct.

**Individual/Partner/Associate/Authorised representative one**

Full name

Signature

Date

**Individual/Partner/Associate/Authorised representative two**

Full name

Signature

Date

**Individual/Partner/Associate/Authorised representative three**

Full name

Signature

Date

**Individual/Partner/Associate/Authorised representative four**

Full name

Signature


Date

**Individual/Partner/Associate/Authorised representative five**

Full name

Signature

Date

 If you have more than five Individual, Partnerships or Authorised Representatives please attach a separate sheet with details.

**Privacy note**

The information provided on this form will be used to change practice details as described in the 'Important information' section. The collection of this information is authorised by the *Human Services (Medicare) Act 1973*. This information may be disclosed to the Department of Health and Ageing or as authorised or required by law.