



# Practice Incentives Program and General Practice Immunisation Incentive

## Practice ownership details

### Important information

Complete this form if you are applying for the Practice Incentives Program (PIP) and/or General Practice Immunisation Incentive (GPII) using the PIP and GPII Online. This form will be used to support the information provided in the practice ownership details section of your online application.

Signatures of all individuals, partners, associates and/or authorised representatives who are owners of the practice must be provided.

### Assistance

For more information about the PIP go to [www.medicareaustralia.gov.au/pip](http://www.medicareaustralia.gov.au/pip) or email [pip@humanservices.gov.au](mailto:pip@humanservices.gov.au). If you need assistance completing this form call the PIP on **1800 222 032** (call charges may apply) between 8.30 am and 5.00 pm, Monday to Friday, Australian Central Standard Time or call the GPII on **1800 246 101** (call charges may apply) between 8.30 am and 5.00 pm, Monday to Friday, Australian Eastern Standard Time.

### Lodgement

Send the completed form to:

**Practice Incentives Program**  
**GPO Box 2572**  
**ADELAIDE SA 5001**

or fax to: **1300 587 696**

Print in **BLOCK LETTERS**

Tick where applicable

### Practice details

**1** Application number

**2** Practice name

**3** Practice address

Postcode

**4** Practice contact number

### Practice Ownership details

**5** Indicate the type of practice ownership arrangement that applies, and complete the declaration below:

**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 (e.g. company director and company secretary).

**State or Territory Government or other Public Body**

Application to be completed by an authorised representative of the practice.   
Penalties exist under law for giving false or misleading statements.

### Declaration

**6 I/we declare that:**

- the statements made in this application and in the accompanying documents are correct.

**I/we consent to the Department of Human Services:**

- providing payment advice(s) showing how PIP and/or GPII payment(s) are calculated for the practice to the authorised contact person nominated on the Practice Details screen
- disclosing information, including personal information, to the Department of Health and Ageing, other relevant agencies or as authorised or required by law
- disclosing practice details to the National Asthma Council Australia, Divisions of General Practice, State Based Organisations or the Australian General Practice Network, if requested on the Individual Incentive screens
- disclosing practice details to the State or Territory cervical screening registers, if requested on the Cervical Screening Incentive screen
- using the information provided by the State or Territory cervical screening registers on the aggregate number of women screened to calculate the PIP Cervical Screening Incentive payments, if requested on the Cervical Screening Incentive screen

- using the information provided by the National Prescribing Service (NPS) on the number of activities undertaken by practice GPs to calculate PIP QPI payments, if applicable.

**I/we understand that:**

- the Department of Human Services may conduct compliance audits of a practice's compliance with the PIP and/or the GP11 eligibility requirements for PIP and/or GP11 payments
- I/we may be required to provide information to the Department of Human Services as evidence of the practice's compliance with the PIP and/or the GP11 eligibility requirements for PIP and/or GP11 payments
- if I/we cannot provide information, as requested by the Department of Human Services, to enable the Department of Human Services to establish the practice's compliance with the PIP and/or the GP11 eligibility requirements for PIP and/or GP11 payments, I/we acknowledge that past PIP and/or GP11 payments may be recovered and that future payments may be suspended or ceased
- the Department of Human Services may provide information (which may include identifying information) relating to this application to the Department of Health and Ageing for statistical, research and policy development purposes.

**I/we agree 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
- advise the Department of Human Services in writing by the relevant 'point in time' date if the required number of procedural services in a six month reference period have not been provided (if applicable).

**7 I/we**

Trading as

of (address)

Postcode

Hereby apply for the:

PIP

and/or


GP11

- 8** Signatures of all individuals, partners, associates and/or authorised representatives who are owners of the practice. If the person has an individual Public Key Infrastructure (PKI) certificate, the Registration Authority (RA) number should be provided in the space provided.


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

The RA number will be used to allow access to the PIP and GP11 Online.


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

Full name	
<input style="width: 100%;" type="text"/>	
Position held	
<input style="width: 100%;" type="text"/>	
RA number (if applicable).	
<input style="width: 100%;" type="text"/>	
Signature	Date
<input style="width: 70%; height: 20px;" type="text"/>	<input style="width: 30%; height: 20px;" type="text"/>
	/ /

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

Full name	
<input style="width: 100%;" type="text"/>	
Position held	
<input style="width: 100%;" type="text"/>	
RA number (if applicable).	
<input style="width: 100%;" type="text"/>	
Signature	Date
<input style="width: 70%; height: 20px;" type="text"/>	<input style="width: 30%; height: 20px;" type="text"/>
	/ /

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

Full name	
<input style="width: 100%;" type="text"/>	
Position held	
<input style="width: 100%;" type="text"/>	
RA number (if applicable).	
<input style="width: 100%;" type="text"/>	
Signature	Date
<input style="width: 70%; height: 20px;" type="text"/>	<input style="width: 30%; height: 20px;" 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"/>	
Signature	Date
<input type="text"/>	<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"/>	
Signature	Date
<input type="text"/>	<input type="text"/>

 If you require more space attach a separate sheet with details.

**Witness details**

Witness's full name	
<input type="text"/>	
Witness's address	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
Postcode	
<input type="text"/>	
Witness's signature	Date
<input type="text"/>	<input type="text"/>

**Privacy note**

The information on this form will be used to assess the practice's eligibility to receive payments under the PIP and/or the GPII and is required by the Department of Human Services to perform functions under service arrangements made under the *Human Services (Medicare) Act 1973*. Information provided on this form may be disclosed to the Department of Health and Ageing, other relevant agencies or as authorised or required by law.