



Medicare Easyclaim banking details for bulk bill claims

Important information

The information provided on this form will be used by Medicare Australia to register your nominated financial institution details for the purposes of making electronic payments.

Assistance

If you need assistance in completing this form, call Medicare Australia on **1800 700 199** (call charges may apply) or visit www.medicareaustralia.gov.au for additional copies of this form.

Lodgement

Send completed and signed form to:

Medicare Australia

eBusiness Service Centre

PO Box 9822

in your capital city

or fax to:

NSW/ACT	02 9895 3190	SA/NT	08 8274 9408
VIC	03 9605 7981	WA	08 9214 8173
QLD	07 3004 5526	TAS	03 6215 5600



Medicare Easyclaim banking details for bulk bill claims

Practice details

1 Practice name

2 Address

 Postcode

3 Authorised contact person's name

4 Work phone number

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5 Fax number

 ()

6 Name of financial institution which supplied your Medicare Easyclaim EFTPOS terminal

Bank account details

Note: a separate form must be completed for each electronic funds transfer account you wish to use. Payments cannot be made to credit card, loan or mortgage accounts.

7 Name of bank, building society or credit union

Branch where account is held

Branch number (BSB)

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Account number (this may not be your card number)

Account held in the name(s) of

8 This account is to be used for providers listed, effective from

 / /

Provider declarations and details

I undertake to:

- immediately notify my pay group(s) or Third Party payee(s) of any current and/or future Notice(s) issued from Medicare Australia to garnish or intercept payments due to me or my provider number(s).

9 Print full name in **BLOCK LETTERS**

Provider number

Provider's signature

10 Print full name in **BLOCK LETTERS**

Provider number

Provider's signature

11 Print full name in **BLOCK LETTERS**

Provider number

Provider's signature

12 Print full name in **BLOCK LETTERS**

Provider number

Provider's signature

13 Print full name in **BLOCK LETTERS**

Provider number

Provider's signature

Privacy note

The information provided on this form will be used to register your nominated financial institution details for the purpose of making electronic payments to you. The collection of this information is authorised by the *Health Insurance Act 1973*. Your bank account details will be disclosed to the relevant financial institution to facilitate payment of your claim and will not be disclosed to any other third party unless authorised or required by law.