



Billing agent—electronic funds transfer (EFT) registration form

Note: A copy of the billing agent registration certificate must be attached.

Please complete this form and return it to:

The Manager, Software Vendor Helpdesk
Medicare Australia
PO Box 1001
Tuggeranong DC ACT 2901

Fax: 02 6124 6633

Phone: 1300 550 115

Email: edihelp@medicareaustralia.gov.au

1. Billing agent information

Billing agent name:

.....

Billing agent registration number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
ACN number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
ABN number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Is data currently being transmitted for other Medicare Australia programs? Yes No

[If yes please indicate the location (minor) ID—three alpha, five numeric]

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Will you be using this number for simplified billing? Yes No

[If no please indicate the location (minor) ID you wish to use—three alpha, five numeric]

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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2. Address information

Physical address of the billing agent:

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State: Postcode:

Postal address for the *Medicare benefits statement* (if different to above):

.....

.....

State: Postcode:

3. Contact person (contact person for all payment enquiries)

Name:

Position:

Phone: (.....) Fax: (.....)

Email:

4. Bank details for electronic funds transfer (EFT)

Trust account name:

Account number: BSB (branch) number:

Bank:

Note: Medicare payment times are made in accordance with the Australian Government's minimum payment times to a trust account registered with Medicare Australia.

5. Declaration

I declare that to my knowledge, all information provided on this form is true and correct. I agree to inform Medicare Australia, without delay, of changes to the billing agent's bank details, or other relevant information.

I am authorised to sign this agreement for and on behalf of the billing agent.

Signature: Date:

Name: Position:
(Please print)

Medicare Australia office use only
Processing date: Processed by:
Operator ID: Source office code: