



Health fund—electronic transmission of Medicare claims agreement

This agreement is between the Commonwealth as represented by the CEO of Medicare Australia (Medicare Australia) and billing agent.

Please complete and sign this agreement 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. Private health fund information

Health fund name:

.....

Health fund location (minor) ID:

ABN number:

Note: the location (minor) ID is the site ID (three alpha, five numeric) number.

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

Name:

Position:

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

Email:

3. Software supplier and communication carrier details:

Software supplier name:

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.....

Communication carrier name:

.....
.....

4. Software requirements

The health fund agrees to assume all responsibility for, and legal obligations in relation to, the establishment and maintenance of the software that it uses to produce and transmit data to Medicare Australia.

The health fund agrees to use software that the supplier of the software warrants is compliant, in that it complies with representations of, and time specified, in the relevant Australian standard formats.

The health fund agrees that Medicare Australia is excluded from any liability for direct and indirect damage including, but not limited to, loss of profits suffered or incurred by the applicant arising directly or indirectly out of any act or omission of the applicant or any of its personnel, in relation to the electronic transmission.

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 health funds address, or other information relevant to this agreement.

I undertake that all of the claims that are lodged with Medicare Australia under this agreement will accurately reflect the service information provided to the health fund.

I am authorised to sign this agreement for and on behalf of the health fund.

Signature: Date:

Name: Position:
(Please print)

Medicare Australia office use only

Processing date: Processed by:

Operator ID: Source office code: