



# Location Specific Practice Number amendment form

## Important information

Complete this form to amend a practice site's Location Specific Practice Number (LSPN) registration details.

In order to maintain registration, practice sites must advise Medicare Australia in writing **within 28 days** of any changes to:

- proprietor details (including the proprietor's address for mobile bases)
- the Australian Company Number (ACN) if the proprietor is a company
- the business name and Australian Business Number (ABN)
- the address of the practice site or base for mobile equipment
- the type of equipment located at the site or base
- information about any provider not employed at, or contracted to provide services for, the site or base who has financial interest in any of the equipment listed on the register.

Failure to notify Medicare Australia of changes to primary information on the LSPN register can result in suspension or cancellation of the registration for the practice site or mobile base. If a practice is over the 28 day period and has not contacted Medicare Australia, claims will not be paid.

A LSPN is location specific, therefore if a registered site is sold or is moving physical location, a new LSPN registration form is required.

## Assistance

If you need assistance completing this form call **1800 620 589** (call charges may apply) between 7.30 am to 5.00 pm, Monday to Friday, Australian Western Standard Time. For more information go to [www.medicareaustralia.gov.au/provider/medicare/lspn.jsp](http://www.medicareaustralia.gov.au/provider/medicare/lspn.jsp)

## Lodgement

Send the completed form to:

**Medicare Australia  
Provider Liaison Section  
GPO Box 9822**

in your capital city

or fax to:

NSW/ACT **02 9895 3439** SA/NT **08 8274 9307**

VIC **03 9605 7984** TAS **03 6215 5700**

QLD **07 3004 5634** WA **08 9214 8201**

Print in **BLOCK LETTERS**

Tick where applicable

## Location Specific Practice Number details

**1** Your Location Specific Practice Number (LSPN)

**2** I would like to (tick all that apply):

Nominate a **new authorised representative** for the LSPN

Amend **business details** contained in the register for the LSPN

Amend **practice details** contained in the register for the LSPN

Amend **equipment details** contained in the register for the LSPN

## Authorised representative details

This section must be completed for partnerships, companies, government agencies and public authorities.

**3** Dr  Mr  Mrs  Miss  Ms  Other

Family name

First given name

**4** Daytime phone number

Fax number

Email address

**5** Position held

## Business details

**6** Registered business name

**7** ABN

**8** What is the nature of your proprietorship?

Individual  **Go to 9**

Partnership  **Go to 10**

Company  **Go to 11**

Government agency or public body  **Go to 13**

## Individual details

### 9 Family name

First given name

## Partnership details

### 10 Full name(s) of all partners

Full name of partner/company one

ACN

 -  - 

Full name of partner/company two

ACN

 -  - 

Full name of partner/company three

ACN

 -  - 

Full name of partner/company four

ACN

 -  - 

If there are more than four partners, attach a separate sheet with details.

## Company details

### 11 Name of company of the practice site or mobile facility

### 12 ACN

 -  - 

## Government agency or public body details

### 13 Name of government agency (proprietor) of the practice site or mobile facility

### 14 ACN

 -  - 

## Practice site details

### 15 Postal address

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Postcode

## Equipment details

### Before completing your equipment details:

- check the number of units you will be registering. If there is insufficient space to record all of your units, photocopy the relevant page for which you are providing details (e.g. if you have more than two ultrasound units, photocopy the required number of ultrasound pages you need)
- staple any additional equipment details to the back of this form
- include your practice name on any additional equipment pages in case they become detached from the form and number each page
- tick the appropriate box for each type of equipment located at this practice site or base for mobile equipment.

### 16 Complete the relevant question(s) with details of the equipment you wish to update.

Ultrasound  **Go to 17**

Transducer  **Go to 18**

Computed Tomography  **Go to 19**

Nuclear Medicine Imaging (PET scanner)  **Go to 20**

Nuclear Medicine Imaging (Gamma Camera)  **Go to 21**

Angiography  **Go to 22**

Diagnostic Radiology  
(X-ray, Mammography, Fluoroscopy and  
Orthopantomography equipment)  **Go to 23**

Magnetic Resonance Imaging (MRI)  **Go to 24**

Radiation Oncology  
Linear accelerators  **Go to 25**

Radiation Oncology  
Cobalt units  **Go to 26**

Radiation Oncology  
Simulators/Localiser units  **Go to 27**

Radiation Oncology  
CT interface planning computers  **Go to 28**

Once you have completed your equipment list **Go to 29** and sign the declaration.

## 17 Ultrasound

### Ultrasound unit

Equipment type:

Doppler

Non-Doppler

With echocardiography?

No

Yes

Serial number

Model/type number

Manufacturer/company

Date manufactured

(for equipment that has previously been used outside Australia)

Date first installed in Australia

(for new equipment or equipment previously used in Australia)

Date operational at site

Date removed (if applicable)

Date upgraded (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 18 Transducer

### Transducer (> 7.5MHz or higher)

Serial number

Model/type number

Manufacturer/company

Date manufactured

(for equipment that has previously been used outside Australia)

Date first installed in Australia

(for new equipment or equipment previously used in Australia)

Date operational at site

Date removed (if applicable)

Date upgraded (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 19 Computed Tomography

### Gantry component (details of gantry only required)

Serial number

Model/type number

Manufacturer/company

Date manufactured

(for equipment that has previously been used outside Australia)

Date first installed in Australia

(for new equipment or equipment previously used in Australia)

Date operational at site

Date removed (if applicable)

Date upgraded (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 20 Nuclear Medicine Imaging

### PET scanner

Serial number

Model/type number

Manufacturer/company

Date manufactured

(for equipment that has previously been used outside Australia)

Date first installed in Australia

(for new equipment or equipment previously used in Australia)

Date operational at site

Date removed (if applicable)

Date upgraded (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 21 Nuclear Medicine Imaging

### Gamma camera

Serial number

Model/type number

Manufacturer/company

Date manufactured

(for equipment that has previously been used outside Australia)

Date first installed in Australia

(for new equipment or equipment previously used in Australia)

Date operational at site

Date removed (if applicable)

Date upgraded (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 22 Angiography

### Angiography

Serial number

Model/type number

Manufacturer/company

Date manufactured

(for equipment that has previously been used outside Australia)

Date first installed in Australia

(for new equipment or equipment previously used in Australia)

Date operational at site

Date removed (if applicable)

Date upgraded (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 23 Diagnostic radiology

### Diagnostic radiology unit

Tick the corresponding box of the diagnostic radiology unit you are registering (**tick one only**):

Fluoroscopy

Mammography

Orthopantomography

X-ray

Serial number

Model/type number

Manufacturer/company

Date manufactured

(for equipment that has previously been used outside Australia)

Date first installed in Australia

(for new equipment or equipment previously used in Australia)

Date operational at site

Date removed (if applicable)

Date upgraded (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 24 Magnetic Resonance Imaging (MRI)

### MRI

Medicare eligible

Non-Medicare eligible

Magnetic strength (tesla units)

Serial number of magnet

Model/type number

Manufacturer/company

Date commissioned

Date manufactured

(for equipment that has previously been used outside Australia)

Date first installed in Australia

(for new equipment or equipment previously used in Australia)

Date operational at site

Date removed (if applicable)

Date upgraded (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 25 Radiation Oncology

### Linear accelerator

Dual modality

Single photon linear

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

Does this linear accelerator have any or all of the following additional features?

MLC

No

Yes

EPI

No

Yes

Date operational at site

Date removed (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 26 Radiation Oncology

### Cobalt unit

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

Date operational at site

Date removed (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 27 Radiation Oncology

### Simulator/Localiser unit

With CT

Without CT

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

Date operational at site

Date removed (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

## 28 Radiation Oncology

### CT interface planning computers

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

Date operational at site


Date removed (if applicable)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No

Yes  Name of provider or business

ABN (if applicable)

 If you have additional equipment, photocopy the relevant page and attach to this form.

## Declaration

### 29 I understand that:

- Medicare Australia may request more information regarding details on this amendment form from the proprietor or authorised representative nominated on this form
- I must notify Medicare Australia of any changes to this information **within 28 days** of the change(s) occurring.

### I declare that:

- the information on this form is correct
- I have the appropriate authority to sign this document in my capacity as:

Proprietor

Authorised representative

For partnerships, companies, government agencies and public bodies, an authorised representative must be nominated.

Full name

Position held

Signature

Date

Company seal

## Privacy note

The information provided on this form will be used to update information registered for your Location Specific Practice Number (LSPN). The collection of this information is authorised by the *Health Insurance Act 1973*. This information may be disclosed to the Department of Health and Ageing or as authorised or required by law. Practice details such as business name, address, allocated LSPN and registration dates will be made available to the public on the Medicare Australia website.