



Location Specific Practice Number registration form

Important information

Complete this form to register for a Location Specific Practice Number (LSPN). A registration form is required for each practice site and must be signed by a proprietor or authorised representative.

Additional copies of this form are available at www.medicareaustralia.gov.au/provider/medicare/lspn.jsp

Your Location Specific Practice Number

- A LSPN will be allocated to your practice site or mobile facility on submission of a completed registration form to Medicare Australia.
- The LSPN will be activated from the date received by Medicare Australia or a future date if requested.
- Medicare Australia will write to your practice to confirm your registration and advise you of your site's LSPN.
- Registered sites and their allocated LSPN's will be published on the Medicare Australia website at www.medicareaustralia.gov.au/provider/medicare/lspn.jsp

Once registered, practice sites must advise Medicare Australia in writing **within 28 days** of any changes to the information provided in this form.

Assistance

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

Lodgement

Send the completed form to:

Provider Liaison Section
GPO Box 9822
PERTH WA 6847

or fax to: **08 9214 8201**

Print in **BLOCK LETTERS**

Tick where applicable

Practice site details

1 Are you registering a:

Practice site

Base for mobile equipment

2 Practice site or mobile facility trading name

If you are registering a hospital department, please state the name of the department (e.g. Radiology Department or Radiology and Nuclear Medicine Department).

3 Location of practice site or base for mobile equipment (must be completed)

Building/property name (if applicable)

Suite Unit Shop

Number Floor number

Address

Postcode

4 Postal address (if different to above)

Postcode

5 Daytime phone number

Fax number

Email

@

Practice site details

Step 1

Decide which of the following best describes the nature of this practice.

Group A:

A private practice specialising in radiology, nuclear medicine and/or radiation oncology.

Group B:

A general practice or private specialist medical practice (not included in Group A).

Group C:

Public facility.

Step 2

Under that group, decide which best describes the type of practice site and then tick the box next to that number (e.g. if your practice site is a specialist radiology site, you would look at Group A and then tick the box under that group that best describes your practice site type).

6 Which best describes the nature of your practice (tick one only).

Group A—Private specialist radiology, nuclear medicine or radiation oncology

- Base for mobile equipment 1
- Stand-alone practice site (provides any of the above services) 2
- Part of or co-located with a primary care practice or group 3
- Part of or co-located with a private specialist medical centre 4
- Co-located with a public hospital 5
- Co-located with a private hospital 6
- Private hospital 7
- Private hospital co-located with a public hospital 8
- Other (give details below) 9

Group B—General practice or private specialist medical practice (not included in Group A)

- Base for mobile equipment 1
- Primary care practice or group 2
- Sports medicine clinic 3
- Cardiology practice or group 4
- Vascular surgery practice or group 5
- Orthopaedic practice or group 6
- Obstetric and gynaecological practice or group 7
- Neurology or neurosurgery practice or group 8
- Urology practice or group 9
- Other (give details below) 10

Group C—Public facility

- Base for mobile equipment 1
- Public Hospital—Campus (if you are registering more than one public hospital department, please tick this box) 2
- Public Hospital—Radiology department 3
- Public Hospital—Nuclear Medicine department 4
- Public Hospital—Radiation Oncology department 5
- Public Hospital—Cardiology department 6
- Public Hospital—Vascular department 7
- Public Hospital—Orthopaedic department 8
- Public Hospital—Obstetrics and gynaecology department 9
- Public Hospital—Neurology or neurosurgery department 10
- Public Hospital—Urology department 11
- Other (give details below) 12

Business details

7 Registered business name

8 Australian Business Number (ABN)

9 What is the nature of your proprietorship?

- Individual **Go to 10**
- Partnership **Go to 11**
- Company **Go to 12**
- Government agency or public body **Go to 13**

Individual details

10 Family name

First given name

Partnership details

11 Full name(s) of all partners

Full name of partner/company one

Australian Company Number (ACN)

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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

12 Name of company of the practice site or mobile facility

13 ACN

Government agency or public body details

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

15 ACN

Authorised representative details

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

16 Dr Mr Mrs Miss Ms Other

Family name

First given name

17 Daytime phone number

Fax number

Email address

18 Position held

Proprietor's details

19 Address for proprietors of mobile bases only - **MUST BE COMPLETED**

Building/property name (if applicable)

Suite Unit Shop

Number Floor number

Address

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.

20 Complete the relevant question(s) with details of your equipment.

Ultrasound **Go to 21**

Transducer **Go to 22**

Computed Tomography **Go to 23**

Nuclear Medicine Imaging (PET scanner) **Go to 24**

Nuclear Medicine Imaging (Gamma Camera) **Go to 25**

Angiography **Go to 26**

Diagnostic Radiology (X-ray, Mammography, Fluoroscopy and Orthopantomography equipment) **Go to 27**

Magnetic Resonance Imaging (MRI) **Go to 28**

Radiation Oncology Linear accelerators **Go to 29**

Radiation Oncology Cobalt units **Go to 30**

Radiation Oncology Simulators/Localiser units **Go to 31**

Radiation Oncology CT interface planning computers **Go to 32**

Once you have completed your equipment list **Go to 33** and sign the declaration.

21 Ultrasound

Ultrasound unit one

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)

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)

Ultrasound unit two

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)

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 Transducer

Transducer one

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)

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)

Transducer two

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)

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 Computed Tomography

Gantry component one (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)

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)

Gantry component two (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)

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 Nuclear Medicine Imaging

PET scanner one

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)

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)

PET scanner two

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)

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 Nuclear Medicine Imaging

Gamma camera one

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)

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)

Gamma camera two

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)

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 Angiography

Angiography one

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)

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)

Angiography two

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)

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 Diagnostic radiology

Diagnostic radiology unit one

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)

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)

Diagnostic radiology unit two

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)

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 Magnetic Resonance Imaging (MRI)

MRI—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)

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)

MRI—Non-Medicare Eligible (optional to complete)

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)

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)

29 Radiation Oncology

Linear accelerator one

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

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)

Linear accelerator two

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

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)

30 Radiation Oncology

Cobalt unit one

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

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)

Cobalt unit two

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

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)

31 Radiation Oncology

Simulator/Localiser unit one

With CT

Without CT

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

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)

Simulator/Localiser unit two

With CT

Without CT

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

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)

32 Radiation Oncology

CT interface planning computers one

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company

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)

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CT interface planning computers two

HPG number (if applicable)

Serial number

Model/type number

Manufacturer/company


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)

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

Proprietor declaration

33 I hereby apply:

- for a LSPN for the practice site or base for mobile equipment described in this form.

I understand that:

- Medicare Australia may request more information regarding details on this registration 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 allocate a 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.

Checklist

Have you ticked whether you are a practice site or base for mobile facility? (question 1)

Have you ticked the nature and type of practice? (question 6)

Have you provided all the details required in the equipment list? (question 20–32)

Have you signed the Declaration? (question 33)

Have you photocopied and completed extra equipment pages and attached to this form?

Have you taken a copy of the registration form for your records?