



# Notification of bank account details for an approved community pharmacy

## Important information

Complete this form if you are registering bank account details for an approved community pharmacy for payments made through Medicare Australia's Online Claiming for Pharmaceutical Benefits Scheme (PBS).

This form should also be used to notify Medicare Australia of any changes to the pharmacy's bank account details.

Medicare Australia must be notified in writing, to the address in the lodgement section below, of changes to bank account details. You will need to allow **nine working days** for the change to take effect.

## Assistance

If you need assistance completing this form call **132 290** (call charges will apply) or go to [www.medicareaustralia.gov.au/pbs](http://www.medicareaustralia.gov.au/pbs)

## Lodgement

Send the completed form to:

**Pharmacy Program Officer**  
**Medicare Australia**  
**GPO Box 9826**  
in your capital city

Tick where applicable

## Pharmacy details

1 Pharmacy trading name

2 Pharmacy approval number

3 Postal Address


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 Postcode

4 Daytime phone number

## Contact person's details

5 Dr  Mr  Mrs  Miss  Ms  Other

Family name

First given name

6 Daytime phone number

Fax number

Email


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## Pharmacy bank account details

7 Select one of the following:

Register new bank account details  **Complete sections 8 and 10**

Amend bank account details  **Complete sections 8, 9 and 10**

8 Name of bank, building society or credit union

Branch where the account is held

Branch number (BSB)

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Account number (this may not be the card number)

Account held in the name(s) of


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9 If notifying Medicare Australia of a change to bank account details, record the old bank account details below.

Name of bank, building society or credit union

Branch where the account is held

Branch number (BSB)

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Account number (this may not be the card number)

Account held in the name(s) of


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## Declaration

This declaration must be signed by all approved persons

### 10 I/we authorise:

- payments to be made into the nominated bank account.

### I/we declare that:

- the information on this form is correct.

#### Approved person one's full name

Approved person one's signature

Daytime phone number

Date

#### Approved person two's full name

Approved person two's signature

Daytime phone number

Date

#### Approved person three's full name

Approved person three's signature

Daytime phone number

Date

#### Approved person four's full name

Approved person four's signature

Daytime phone number

Date

#### Approved person five's full name

Approved person five's signature

Daytime phone number


Date

#### Approved person six's full name

Approved person six's signature

Daytime phone number

Date

 If more than 6 approved person's signatures are required complete an additional separate new form with all required details.

### Privacy note

The information on this form will be used to register bank account details for payments made through Medicare Australia's Online Claiming for PBS. The collection of this information is authorised by the *National Health Act 1953*. This information may be disclosed to the Department of Health and Ageing, your financial institution to facilitate payments, other government agencies or as authorised or required by law.