Add or change Approved Aged Care Service's bank details

Important information

Use this form to supply new or updated bank details for Residential Aged Care Services, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) services, Extended Aged Care at Home Dementia (EACHD) services and Transition Care (TC) services.

A separate form is required for each aged care home, CACP, EACH service, EACHD service and TC service.

This authorisation replaces all preceding authorisations and previous forms.

This form must be signed by two key personnel or the Approved Provider (for a sole Director Company).

Assistance

If you need assistance completing this form or would like more information about Aged Care call **1800 195 206** (call charges may apply) between 8.30 am and 5.00 pm EST, Monday to Friday or go to **www.medicareaustralia.gov.au** > **Aged Care** > **Forms**

Lodgement

Only original and complete forms sent by post will be accepted. Forms that have been photocopied, emailed or sent by fax or that are incomplete will be returned to the Approved Provider.

Send the completed form to:

Aged Care
Medicare Australia
GPO Box 9923
in your capital city

For services located in:

NT send to: **Adelaide SA 5001**
ACT send to: **Sydney NSW 2001**
TAS send to: **Melbourne VIC 3001**

Print in **BLOCK LETTERS**

Tick where applicable ☑

Approved provider's details

1 Approved provider's name

Service name

Service address

Postcode

2 Service ID

3 Type of service (tick one only)

Residential ☐ CACP ☐ EACH ☐ EACHD ☐ TC ☐

4 ABN

Bank account details

5 Indicate if you are adding or changing your bank details.

Add ☐

Change ☐

6 Name of bank, building society or credit union

Branch where the account is held

Branch number (BSB)

–

Account number (this may not be the card number)

Account held in the name(s)

Declaration

7 **I declare that:**

- as Key Personnel I have the authority to sign this document
- the information on this form is correct.

Authorised person's full name

Position held

Phone number

( )

Authorised person's signature

✍

Date

/ /

Continued over the page ▶▶

Authorised person's full name

Position held

Phone number

(   )

Authorised person's signature

✍

Date

/   /

Privacy note

The information provided on this form will be used to register and store your bank account details for the purpose of making electronic payments to you from programs administered by Medicare Australia. The collection of this information is authorised by the *Medicare Australia Act 1973*. Your bank details will be disclosed to the relevant financial institution to facilitate payments to you and will not be disclosed to any other third party unless authorised or required by law.

Office use only

Entered by

/   /

Verified by

/   /