



Authorisation Form

For use by Community Care Services participating in Aged Care online claiming

Important information

To complete this application, please read the following terms, conditions and information carefully and send your completed form to:

eBusiness Service Centre
GPO Box 9822
In your Capital City.

Note: ACT Providers please send form to Sydney
NT Providers please sent form to Adelaide

This form is to be used by Aged Care Services that are registering or are registered for Aged Care Online Claiming. Use this application to:

- register to participate in Aged Care Online Claiming. Each Service wishing to participate must complete and sign this form accepting the terms and conditions. Access is granted to each individual Service and appropriate staff as indicated by each Service on this application.
- notify Medicare Australia of those person/s authorised to sign data **electronically** with individual certificates and/or the Service's site certificate.
- request access for aged care staff to use Aged Care Online Claiming to browse, request reports and submit data that has been signed by an authorised person.

Note: this authorisation will be used in conjunction with previous authorisations of signatories. In the event of additional access requests, additional pages may be inserted in the form.

If you have any queries regarding registering for Aged Care Online Claiming please contact the eBusiness Service Centre on **1800 195 206** or email agedcare.ebus.help@medicareaustralia.gov.au

Application for Online Claiming Authorisation for Aged Care

Approved provider application and terms and conditions for electronic payment of subsidies under the Aged Care Act 1997

Is this

A new application for this Service?

Note: Services registering to transmit data must complete the data synchronisation process

An amendment to an existing application for this Service?

Do you have a current annual approved provider statement in place? YES / NO

Is the channel being used by the Service;

B2B Please refer to Sections 1, 4, 5, 6, 7 and 8 only

File Upload Please refer to Sections 1, 2, 3, 6, 7 and 8 only

Website only Please refer to Sections 1, 7 and 8 only

1 Community Service Details

Note: This section must be completed

Name of Aged Care Service		Service Id	
Street Number & Name			
Suburb/Town			
State/Territory		Postcode	
Contact Name	TITLE GIVEN NAME SURNAME	Phone Number	()
		Fax number	()
Email Address			
Internet Service Provider (ISP)		Type of Connection	Dial-up <input type="checkbox"/> Broadband <input type="checkbox"/>

When completing sections 2, 3, 4 and 5 of the form:

- Details of at least 1 location (Service or Administrative) must be completed
This includes:
 - Minor Customer Id (required)
 - Start Date (required)
 - End Date (optional)
 - Software Vendor (required)
 - Location Certificate Details (required, B2B channel only)
- The Minor Customer Id and Service location site details provided in section's 2 and 5 of the form must be unique to this Service;
- Minor Customer Id - the Service must have approved software with a 'Minor Customer Id' issued by a software vendor;
- Start Date - the start date of the Service association with the software vendor;
- End Date - only required if the Service is no longer associated with the software vendor, or if the Service association with the software vendor is for a defined period;
- Software Vendor Name – name of the software vendor supplying software; and
- The Contact Person nominated in the location site certificate details will be sent the certificate and pass phrase (applicable to B2B channel only).

File Upload Channel

2 Service Location

Note: This section is only required to be completed if a Service Location is being used to transmit.

Please indicate the software vendor to be used by the service location:

Minor Customer Id		Start Date		End Date	
Software Vendor Name					

3 Administration Location

Note: One administrative location may be linked to one or more Service with a maximum of two administrative locations per Service.

Administration Location 1

Note: This section is only required to be completed if an administrative location is being used to transmit.

Administration Location Name					
Street Number & Name					
Suburb/Town					
State/Territory				Postcode	
Contact Person Name	TITLE	GIVEN NAME	SURNAME		
Email Address					
Contact Phone Number	()				

Please indicate the software vendor to be used by administration location 1:

Minor Customer Id		Start Date		End Date	
Software Vendor Name					

Administration Location 2

Note: This section is only required to be completed if a 2nd administrative location is being used to transmit.

Administration Location Name					
Street Number & Name					
Suburb/Town					
State/Territory				Postcode	
Contact Person Name	TITLE	GIVEN NAME	SURNAME		
Email Address					
Contact Phone Number	()				

Please indicate the software vendor to be used by administration location 2:

Minor Customer Id		Start Date		End Date	
Software Vendor Name					

B2B Channel

4 Service Location

Note: This section is only required to be completed if a service location is being used to transmit.

Please indicate the software vendor to be used by the service location:

Minor Customer Id		Start Date		End Date	
Software Vendor Name					

Service location site certificate details

Has the site been previously issued with or requested a site certificate?	Yes <input type="checkbox"/>	Please provide the site certificate RA number	
	No <input type="checkbox"/>	Medicare Australia will request a site certificate on behalf of the transmission site. Please select either CD <input type="checkbox"/> or Floppy <input type="checkbox"/>	
Contact Person Name	TITLE	GIVEN NAME	SURNAME
Email address			
Contact Phone Number	()	Fax Number	()

5 Administration Location

Note: One administrative location may be linked to one or more Services with a maximum of two administrative locations per Service.

Administration Location 1

Note: This section is only required to be completed if an administrative location is being used to transmit.

Administration Location Name			
Street Number & Name			
Suburb/Town			
State/Territory		Postcode	
Contact Person Name	TITLE	GIVEN NAME	SURNAME
Email Address			
Contact Phone Number	()	Fax Number	()

Please indicate the software vendor to be used by administration location 1:

Minor Customer Id		Start Date		End Date	
Software Vendor Name					

Administration Location Site Certificate Details (required for use with B2B)

Has the site been previously issued with or requested a site certificate?	Yes <input type="checkbox"/>	Please provide the site certificate RA number	
	No <input type="checkbox"/>	Medicare Australia will request a site certificate on behalf of the transmission site. Please select either CD <input type="checkbox"/> or Floppy <input type="checkbox"/>	

continued over page

Administration Location 2

Note: This section is only required to be completed if a 2nd administrative location is being used to transmit.

Administration Location Name			
Street Number & Name			
Suburb/Town			
State/Territory		Postcode	
Contact Person Name	TITLE	GIVEN NAME	SURNAME
Email Address			
Contact Phone Number	()	Fax Number	()

Please indicate the software vendor to be used by administration location 2:

Minor Customer Id		Start Date		End Date	
Software Vendor Name					

Administration Location Site Certificate Details (required for use with B2B)

Has the site been previously issued with or requested a site certificate?	Yes <input type="checkbox"/>	Please provide the site certificate RA number	
	No <input type="checkbox"/>	Medicare Australia will request a site certificate on behalf of the transmission site. Please select either CD <input type="checkbox"/> or Floppy <input type="checkbox"/>	

File Upload and B2B Channels

6 Contact Details for Held and Rejected Event Reporting

Note: Please advise if you would like to specify additional contact names to receive the held and rejected reporting notification emails. This Section is optional, it is only required to be completed if different to nominated contact person in Section 1

Contact Name	TITLE GIVEN NAME SURNAME	Phone Number	()
Position		Fax Number	()
Email Address			
Please indicate if you would like to specify additional contact people to receive Held and Rejected reporting notifications		Yes <input type="checkbox"/>	No <input type="checkbox"/>

7 Authorisation of Person/s

When completing section 7 of the form:

- If a person has previously been authorised and issued with an RA number or an aged care online claiming User Id (possibly with another Service) please provide the RA Number or User Id in the appropriate section.
- The date of effect is the date on which the authority to sign will commence.
- The 'end date with Service' is optional. Please provide this date to advise Medicare Australia if a person requires access to the Aged Care system for a defined period or when a person no longer requires access to the Aged Care system.
- A person authorised to **sign data** for lodgment via B2B or File Upload channels is automatically provided with access to view data on the website.
- A person authorised to **enquire** is provided with browse only access to the website.
- A person authorised to **view/download** a payment statement is provided with view/download for payment statements

Valid combinations for Authorisations are:

Item 1 only	Item 2 only	Item 3 only	Item 1 and Item 3	Item 2 and Item 3
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*For File Upload and B2B Services only

Does your Software incorporate the Annual Aged Care Provider Statement? YES / NO

(ie. Userids will be issued instead of Individual Certificates)

The person(s) nominated below are authorised as indicated.

1.	Title:	Name: GIVEN NAME SURNAME
	Email address:	Fax Number: ()
	PKI Registration Authority (RA) number: RA _____	Please provide your previous Aged Care User Id (if applicable) A _____

Authorisation (tick appropriate boxes)

<input checked="" type="checkbox"/> Item 1 Enquiry and data signing	<input checked="" type="checkbox"/> Item 2 Enquiry only (not data signing)	<input checked="" type="checkbox"/> Item 3 View/download payment statement/s
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Date of effect	/ /	End date with Service	/ /	(if applicable)
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2.	Title:	Name: GIVEN NAME SURNAME
	Email address:	Fax Number: ()
	PKI Registration Authority (RA) number: RA _____	Please provide your previous Aged Care User Id (if applicable) A _____

Authorisation (tick appropriate boxes)

<input checked="" type="checkbox"/> Item 1 Enquiry and data signing	<input checked="" type="checkbox"/> Item 2 Enquiry only (not data signing)	<input checked="" type="checkbox"/> Item 3 View/download payment statement/s
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Date of effect	/ /	End date with Service	/ /	(if applicable)
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3.	Title:	Name: GIVEN NAME SURNAME
	Email address:	Fax Number: ()
	PKI Registration Authority (RA) number: RA _____	Please provide your previous Aged Care User Id (if applicable) A _____

Authorisation (tick appropriate boxes)

<input checked="" type="checkbox"/> Item 1 Enquiry and data signing	<input checked="" type="checkbox"/> Item 2 Enquiry only (not data signing)	<input checked="" type="checkbox"/> Item 3 View/download payment statement/s
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Date of effect	/ /	End date with Service	/ /	(if applicable)
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4.	Title:	Name: GIVEN NAME SURNAME
	Email address:	Fax Number: ()
	PKI Registration Authority (RA) number: RA _____	Please provide your previous Aged Care User Id (if applicable) A _____

Authorisation (tick appropriate boxes)

<input checked="" type="checkbox"/> Item 1 Enquiry and data signing	<input checked="" type="checkbox"/> Item 2 Enquiry only (not data signing)	<input checked="" type="checkbox"/> Item 3 View/download payment statement/s
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Date of effect	/ /	End date with Service	/ /	(if applicable)
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5.	Title:	Name: GIVEN NAME SURNAME
	Email address:	Fax Number: ()
	PKI Registration Authority (RA) number: RA _____	Please provide your previous Aged Care User Id (if applicable) A _____

Authorisation (tick appropriate boxes)

<input checked="" type="checkbox"/> Item 1 Enquiry and data signing	<input checked="" type="checkbox"/> Item 2 Enquiry only (not data signing)	<input checked="" type="checkbox"/> Item 3 View/download payment statement/s
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Date of effect	/ /	End date with Service	/ /	(if applicable)
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8 This section MUST be completed

Please note that this section can only be signed by key personnel of the approved provider as defined in the *Aged Care Act 1997*.

The signature below provides authorisation for the nominated authorised persons.

I wish to conduct transactions with Medicare Australia electronically using online claiming for Aged Care.

I understand and agree to the terms and conditions set out below in respect of transactions conducted with Medicare Australia using online claiming for Aged Care.

Title:	Name: GIVEN NAME SURNAME
Position:	

Signature.....**Date** / /

Please note that a copy of this form may be sent to the Department of Health and Ageing.

Privacy Note:

The information provided on this form will be used to register for Aged Care Online Claiming. This information will be retained on Medicare Australia records and will not be disclosed to a third party unless authorised or required by law.

AGED CARE APPROVED PROVIDER PARTICIPATION TERMS AND CONDITIONS

1. I/we agree to:

- a) comply with these terms and conditions for online claiming for Aged Care;
- b) ensure that all information I provide and representations I make to Medicare Australia are complete and accurate;
- c) promptly notify Medicare Australia in the event that I consider any information provided, or representations made by me is or may be incorrect or misleading (giving false or misleading information is a serious offence under the *Criminal Code Act 1995*);
- d) use a version of a software product approved by Medicare Australia when conducting transactions with Medicare Australia using online claiming for Aged Care. I understand that Medicare Australia may revoke its approval of a version of a software product at any time;
- e) if required for transmission, ensure my site certificate is loaded into my software in accordance with instructions and store it in a safe place once loaded;
- f) not send any personal information (as defined in the *Privacy Act 1988*) to Medicare Australia using online claiming for Aged Care unless the information is encrypted using my site or applicable certificate;
- g) sign and secure all communications I send to Medicare Australia for online claiming for Aged Care using PKI software approved by Medicare Australia at the time of the dispatch of the communication and, if required for transmission, my site certificates (valid at the time of dispatch of the communication).

2. I agree that:

- a) by approving a particular version of a software product, Medicare Australia is not representing that the product is suitable for any purpose or that the product meets any quality standards;
- b) Medicare Australia may from time to time change its technical requirements in relation to use of online claiming for Aged Care, which may require me to upgrade my software;
- c) Medicare Australia is not responsible for any costs, losses or damage I (or people acting on my behalf) incur in connection with online claiming for Aged Care (including, without limitation, communications costs, support costs, software acquisition or support costs or losses associated with online claiming for Aged Care being from time to time inoperative or inaccessible);
- d) Medicare Australia may change or add to these terms at any time, by giving me notice by mail, by fax or electronically. A message sent to my business email address (as held in Medicare Australia records) is one way of giving me notice electronically;

- e) if I use online claiming for Aged Care after I have been notified of a change or addition to these terms, I will be taken to have agreed to the change or addition in respect of all uses of online claiming for Aged care after that date. These terms may not be otherwise changed orally or by conduct by me;
- f) I must ensure that my agents do not do anything that these terms prevent me from doing;
- g) Medicare Australia may provide this application and Terms and Conditions to the Department of Health and Ageing, Department of Human Services and any of its agencies;
- h) Medicare Australia may, at its absolute discretion, at any time suspend or terminate my right to communicate with Medicare Australia using online claiming for Aged Care, whether because of a breach of these terms or for any other reason;
- i) I may terminate this contract with Medicare Australia at any time by giving a written notice to Medicare Australia. I understand that I will not be able to conduct transactions with Medicare Australia using online claiming for Aged Care after I give such notice;
- j) If this agreement is terminated, my obligations under these Terms and Conditions will continue in respect of any claims I made using online claiming for Aged Care before the date of termination;

3. I agree that

- a) any use of online claiming for Aged Care by a person acting on my behalf is taken to be a use of online claiming for Aged Care by me;
- b) I must maintain an electronic record (in a retrievable and readable form) of all online claiming for Aged Care transactions as required by the *Aged Care Act 1997*;
- c) the approved provider is responsible for and must:
 - i. determine the items for which each person is authorised and set out that authorisation for each person in this application and terms and conditions;
 - ii. promptly notify Medicare Australia of all changes to authorised persons, including removal of previously authorised persons and addition of new persons;

Failure to do so may result in revocation or termination of my access and use of online claiming for Aged Care.

4. These terms and conditions are issued under and are to be construed in accordance with the laws in force from time to time in the Australian Capital Territory and the parties agree to submit to the courts having jurisdiction in the Australian Capital Territory.