



## Bank account details for immunisation providers

### Important information

Complete this form if you would like Medicare Australia to store your bank account details for the purpose of making Australian Childhood Immunisation Register (ACIR) payments.

If payments are to be made into different bank accounts for some practice locations, complete and send an additional copy of this form.

If you have payments to be made into the same bank account for more than three practice locations, attach a separate sheet with the additional Medicare provider/ACIR registration number, phone and fax details.

Any changes or amendments to this form must be initialled by the signatory.

### Assistance

If you need assistance completing this form call **1800 653 809** (call charges may apply). For more information about ACIR go to [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) > **For health professionals > Other programs – information for health professionals > Australian Childhood Immunisation Register**

### Lodgement

Send the completed form to:

**Medicare Australia**  
**GPO Box M933**  
**Perth WA 6843**

or fax to: **08 9254 4810**

Print in **BLOCK LETTERS**

Tick where applicable

### Immunisation provider details

**1** Individual or organisation name

**2** Include all Medicare provider/ACIR registration numbers you would like linked to the nominated bank account.

**1** Medicare provider/ACIR registration number

Work phone number

Fax number

**2** Medicare provider/ACIR registration number

Work phone number

Fax number

**3** Medicare provider/ACIR registration number

Work phone number

Fax number

### Bank account details

**3** Name of bank, building society or credit union

Branch where the account is held

Branch number (BSB)

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Account number

Account name

### Declaration

**4** I declare that:

- the information on this form is correct.

I authorise:

- Medicare Australia to direct all payments relating to the ACIR for the locations indicated above to the nominated bank account.

Provider's full name

Provider's signature

Date

### Privacy note

The information provided on this form will be used by the Australian Childhood Immunisation Register to register your nominated banking details for the purpose of making electronic payments. The collection of this information is authorised by the *Health Insurance Act 1973*. This information will be disclosed to the relevant financial institution to facilitate payment of your claim and will not be disclosed to any other third party unless authorised or required by law.