



# Application for recognition as an Accredited Orthodontist

(For the purposes of Section 3(1) of the *Health Insurance Act 1973*)

Recognition as an Accredited Orthodontist will allow prescribed dental patients to receive Medicare benefit rebates under the Cleft Lip and Cleft Palate Scheme.

## Section 1—Personal details

Title Dr  Mr  Mrs  Ms  Miss  Other (please specify)

Family name  First name

Other given names  Date of birth  /  /  Gender M/F

Provider number

## Section 2—Qualifications

Specialist qualification  Year obtained

## Section 3—Personal contact details

For this application only  For general mailout purposes

|  |   |
|--|---|
| Telephone number (during business hours)<br><input type="text"/> | Street details<br><input type="text"/>  |
| Mobile<br><input type="text"/>                                   | OR Postal details PO Box number <input type="text"/> or GPO Box number <input type="text"/> |
| Facsimile number<br><input type="text"/>                         | Suburb/Locality<br><input type="text"/>   |
| Pager<br><input type="text"/>                                    | State <input type="text"/> Postcode <input type="text"/>                                    |
|  | Email<br><input type="text"/>   |

## Section 4—Registration

Are you currently registered as an accredited orthodontist under the law of a State or Territory? Yes  No

If "YES", a current copy of your specialist registration as an orthodontist with the State or Territory Dental Board where you are practising must be supplied.

## Section 5—Declaration

I declare that, to the best of my knowledge and belief, all the information provided on this application form is true and correct.

Signature of applicant  Date  /  /

**Privacy Notes:** Information provided by you on this form will be used to assess your application for recognition as an Accredited Orthodontist for the purposes of the Medicare program. The collection of this information is authorised by the *Health Insurance Act 1973* and may be disclosed to the Department of Human Services, Department of Health and Ageing, Department of Veterans' Affairs, private health funds and other approved organisations or as authorised or required by law.

## Section 6—Lodgement details

When completed, please post to:

**Medicare Australia Provider Eligibility Section**  
PO Box 1001, Tuggeranong DC ACT 2901

OR

Via facsimile to: (02) 6124 7600

**Please note:** Where applications are faxed, you must retain your original documents for auditing purposes.

**Enquiries:** Telephone 132 150 (8:30am to 5:00pm Monday to Friday) or email [medicare.prov@medicareaustralia.gov.au](mailto:medicare.prov@medicareaustralia.gov.au)