



**AUSTRALIAN HEALTH SERVICE ALLIANCE**  
**Electronic Funds Transfer Form for Hospitals**

Please return via email to: [assistance@ahsa.com.au](mailto:assistance@ahsa.com.au)  
 Phone 1800 664 277 (option 2)  
 AHSA, Level 1A 35 Cotham Road, Kew, Victoria 3101

**PLEASE RETURN THIS FORM FULLY COMPLETED**

**BANKING DETAILS**

Hospital Name:	
Hospital Address:	
Hospital ABN:	
Hospital Provider No:	
Legal Entity/Owner Name:	
Legal Entity/Owner Address	
Owner ABN:	
Hospital Bank:	
Hospital Branch:	
Hospital Account Name:	
Hospital BSB Number:	
Hospital Account Number:	
Hospital is Eclipse Live for IHC	YES <input type="checkbox"/> NO <input type="checkbox"/>

**REMITTANCE DETAILS**

Hospital Contact Name/Area:	
Position/Title:	
Hospital Contact Phone No:	
Hospital E-mail Address for Remittances:	
Hospital Postal Address for Remittances:	
Hospital Remittance State / Postcode:	

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I authorise the Australian Health Service Alliance Limited (ABN 75 062 860 584) to keep a record of the above account details and to provide those details to some or all of the health benefit funds which are members of AHSA for the purposes of allowing those funds to electronically transfer monies directly to the bank account details above. AHSA will not accept responsibility if the bank details provided by you are incorrect or subsequently changed without 14 days written notice using this form. I am authorised to provide this direct credit authorisation on behalf of the hospital/s specified above.

Effective 21.04.2026