Australian Health Service Alliance

Access Gap Cover

PROVIDER DETAILS & DIRECT CREDIT AUTHORITY

PLEASE WRITE CLEARLY TO ENSURE ACCURACY

This information will be forwarded to our participating health funds, to save you providing your details multiple times. Australian Health Service Alliance Limited ACN 062 860 584 (**AHSA**) will not accept responsibility if the bank account details provided by you are incorrect or subsequently changed without 14 days written notice using this form.

Part 1 : Practitioner Details

Practitioner's Name (Title, Given Name & Surname)

Practitioner Telephone

Practitioner Personal Mobile *

Practitioner Personal E-mail *

AHPRA number(s)

Medical Specialty(s)

* The personal Mobile phone number and personal E-mail address of the practitioner must be supplied. These may be used by AHSA to authenticate and confirm future changes to registration information, to protect against fraud.

Part 2 : Practice Location

Provider Number (use Attachment 3A for additional provider numbers)

Practice Address (Street Address)

*Please refer to Part 6 regarding publication of your details.

Suburb

State

Postcode

Practice Telephone

Practice Fax

Part 3 : Billing Contact Details

Contact details for all matters related to billing

Contact Name (Given Name & Surname)

Postal address for all correspondence related to billing

Billing Name (or name of Registered Billing Agent if you have one)

Postal Address

Suburb

State

Postcode

Billing Telephone

Billing Fax

Please send this form to either:
Fax: ***1800 670 898*** or *Email:* ***access@ahsa.com.au***
PLEASE NOTE: We will notify you via email to commence billing

Part 4 : Email Address for AHSA Correspondence

Please provide a generic business email address (not an individual's) so AHSA can email you links to updated Access Gap Cover (**AGC**) schedules and other correspondence relating to AHSA business. An AGC participating health fund (**Fund**) will only use this e-mail address for claims reconciliation with your consent.

Generic e-mail address for AHSA correspondence:

Part 5 : Bank Details

Please Note: You must complete ALL fields accurately. AHSA requires all your details to successfully process your authority with the bank.

Financial Institution Name

Branch

Account Name

BSB Number

Account Number (9-digits)

Part 6 : Authorisation / Collection, Disclosure and use of Information Provided

I authorise AHSA to keep a record of the bank details in Part 5 and provide them to each Fund, for the purpose of allowing Funds to electronically transfer monies directly to that account. I understand that if I provide another person's account details, monies will be transferred into that person's account.

As a condition of my AGC registration, I agree that:

- The terms and conditions that apply to AGC are set out in the **Agreement**, consisting of the "Billing Guide", the "Terms and Conditions" and the "AGC Schedules". I have read and understood the Agreement, and will comply with it and will direct my billing staff to comply with it.
- If I submit an AGC claim after AHSA has given notice of variation under the Agreement, this means that I have irrevocably consented to that variation.

I further agree that AHSA and Funds may in their discretion:

- Collect information from this form and my other communications with AHSA and Funds (including forms and communications received before this condition came into effect and information from claims that I submit). This includes personal information (such as my name, practice address, and other contact details); my field of practice and additional qualifications or specialties, and information (including past claims data) relating to the charges I have rendered, the services that I provide (including where I operate and my surgical partners) and my participation in the AGC scheme (together, the Information).
- Disclose the Information and other information about me to the public, including Fund members and referring doctors, including for the purposes of identifying AGC providers, and setting out information relating to the charges rendered, quality of service and statistical information relating to my participation in the AGC scheme.
- Use the Information for internal statistical analysis.

Practitioner's Signature

Date

To assist with authentication, please ensure the following documentation is attached:

- Your redacted bank statement.
- Your Medicare confirmation letter for Provider Numbers.
  If not available, submit a PRODA screenshot showing:
  - Date/time stamp & URL address.
  - Health Professional Online Services (HPOS) or Medicare Australia Header
  - All associated provider number information

Australian Health Service Alliance

Access Gap Cover

ADDITIONAL PRACTICE LOCATIONS

ATTACHMENT 3 (Page 2)

Please use the Change of Registration Details form to update your current information.

As a condition of my AGC registration, I agree that:

- The terms and conditions that apply to AGC are set out in the **Agreement**, consisting of the "Billing Guide", the "Terms and Conditions" and the "AGC Fee Schedules". I have read and understood the Agreement and will comply with it and will direct my billing staff to comply with it.
- If I submit an AGC claim after AHSA has given notice of variation under the Agreement, this means that I have irrevocably consented to that variation.

I further agree that AHSA and Funds may in their discretion:

- Collect information from this form and my other communications with AHSA and Funds (including forms and communications received before this condition came into effect and information from claims that I submit). This includes personal information (such as my name, practice address, and other contact details); my field of practice and additional qualifications or specialties, and information (including past claims data) relating to the charges I have rendered, the services that I provide (including where I operate and my surgical partners) and my participation in the AGC scheme (together, the Information).
- Disclose the Information and other information about me to the public, including Fund members and referring doctors, including for the purposes of identifying AGC providers, and setting out information relating to the charges rendered, quality of service and statistical information relating to my participation in the AGC scheme.
- Use the Information for internal statistical analysis.

1st Additional Practice Location

1st Provider Number

1st Practice Address (Street Address)

*Please refer to info above regarding publication of your details.

1st Suburb | 1st State | 1st Postcode

1st Practice Telephone | 1st Practice Fax

2nd Additional Practice Location

2nd Provider Number

2nd Practice Address (Street Address)

*Please refer to info above regarding publication of your details.

2nd Suburb | 2nd State | 2nd Postcode

2nd Practice Telephone | 2nd Practice Fax

3rd Additional Practice Location

3rd Provider Number

3rd Practice Address (Street Address)

*Please refer to info above regarding publication of your details.

3rd Suburb | 3rd State | 3rd Postcode

3rd Practice Telephone | 3rd Practice Fax

4th Additional Practice Location

4th Provider Number

4th Practice Address (Street Address)

*Please refer to info above regarding publication of your details.

4th Suburb | 4th State | 4th Postcode

4th Practice Telephone | 4th Practice Fax

5th Additional Practice Location

5th Provider Number

5th Practice Address (Street Address)

*Please refer to info above regarding publication of your details.

5th Suburb | 5th State | 5th Postcode

5th Practice Telephone | 5th Practice Fax

6th Additional Practice Location

6th Provider Number

6th Practice Address (Street Address)

*Please refer to info above regarding publication of your details.

6th Suburb | 6th State | 6th Postcode

6th Practice Telephone | 6th Practice Fax

To assist with authentication, please ensure the following documentation is attached:

- Your redacted bank statement.
- Your Medicare confirmation letter for Provider Numbers.
  If not available, submit a PRODA screenshot showing:
  - Date, time stamp and URL address.
  - Health Professional Online Services (HPOS) or Medicare Australia Header
  - All associated provider number information

Please send this form to either:
Fax: ***1800 670 898*** or *Email:* ***access@ahsa.com.au***
PLEASE NOTE: We will notify you via email to commence billing

PROVIDER DETAILS & DIRECT CREDIT AUTHORITY FORM

CHECKLIST

- ❑ All fields have been completed on page 1 (and on Page 2 where required).
- ❑ You have provided the personal mobile phone number and personal e-mail address of the practitioner in Part 1.

  (This is important so that AHSA can authenticate and confirm future changes to registration information which helps to protect against fraud).
- ❑ You have attached your Medicare letter of confirmation for each provider number submitted on the form. If not available, submit a PRODA screenshot showing:
  - Date, time stamp and URL address.
  - Health Professional Online Services (HPOS) or Medical Australia Header.
  - All associated provider number information.
- ❑ You have attached your redacted bank statement that relates to the Bank Details in Part 5.
- ❑ You have signed and dated the form.

- USE THIS FORM TO REGISTER YOUR PROVIDER NUMBERS TO ACCESS GAP COVER.
- AHSA WILL CONFIRM YOUR REGISTRATION VIA EMAIL.
- PLEASE NOTE REGISTRATIONS & CHANGES CAN TAKE UP TO 14 DAYS TO PROCESS.