CHANGE OF REGISTRATION DETAILS FORM

ATTACHMENT 4

This form may be used for changes to contact information, address, and bank information for currently registered provider numbers only.
Please use the Provider Details & Direct Credit Authority form to register new provider numbers.

Practitioner's Name: _____

Practitioner's Personal Email * : _____

Practitioner's Personal Mobile * : _____

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

Provider numbers that require updating (Do not add new provider numbers here).

■	■	■	■
■	■	■	■
■	■	■	■

Part 1. Changes to Billing Contact Details

❑ No change required.

CURRENT DETAILS	NEW DETAILS
Contact Name (Given Name & Surname):	Contact Name (Given Name & Surname – primary contact only):
_____	_____
Job title: _____	Job Title: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
E-mail: _____	E-mail: _____
Postal Address:	Postal Address:
_____	_____
_____	_____
_____	_____

It is the responsibility of the Doctor to notify AHSA of any changes to the above-mentioned details.

Effective 1 Oct 2024

Australian Health Service Alliance

Access Gap Cover

Part 2. Provider Numbers to be Terminated

❑ No change required.

Provider Name: _____

Complete the appropriate fields below or attach your own list.

Provider Number	Practice Location	Reason for Termination	Effective Date

It is the responsibility of the Doctor to notify AHSA of any changes to the above-mentioned details.

Australian Health Service Alliance

Access Gap Cover

Part 3. Changes to Bank Details

❑ No change required.

CURRENT DETAILS	NEW DETAILS
Financial institution Name: _____	Financial institution Name: _____
Branch: _____	Branch: _____
Account Name: _____	Account Name: _____
BSB Number: ☐☐☐/☐☐☐	BSB Number: ☐☐☐/☐☐☐
Account Number (max 9 digits): _____	Account Number (max 9 digits): _____

IF THERE IS A CHANGE TO YOUR BANK DETAILS, TO ASSIST WITH AUTHENTICATION:

- CURRENT DETAILS AT PART 1 MUST BE COMPLETED FOR ANY CHANGE REQUEST TO BANK DETAILS.
- PLEASE ATTACHED YOUR REDACTED BANK STATEMENT AND SUBMIT WITH THIS FORM.

Practitioner's Signature

Date

I authorise AHSA to keep a record of the bank details in Part 3 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.

Please return this form to either:

Fax: ***1800 670 898*** or *Email:* ***access@ahsa.com.au***

PLEASE NOTE: The email address that we already have on file for you will be used by AHSA to confirm the requested changes.

It is the responsibility of the Doctor to notify AHSA of any changes to the above-mentioned details.

Effective 1 Oct 2024

CHANGE OF REGISTRATION DETAILS FORM

CHECKLIST

- ❑ All fields have been completed. (If changes are not required, please tick the 'No change required' box).
- ❑ You have provided the personal mobile phone number and personal e-mail address of the practitioner at the top of the form.

  (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 redacted bank statement if there are changes to the Bank Details at Part 3.
- ❑ Current Details at Part 1 have been completed if you have requested a change to your bank details.
- ❑ You have signed and dated the form.

- USE THIS FORM TO CHANGE ANY OF YOUR CURRENT DETAILS INCLUDING BANK DETAILS, BILLING CONTACT INFORMATION (EMAILS, PHONE, FAX, CONTACT PERSON, POSTAL ADDRESS).
- IT CAN ALSO BE USED TO TERMINATE PROVIDER NUMBERS THAT ARE NO LONGER USED.
- AHSA WILL CONFIRM YOUR REGISTRATION VIA EMAIL.
- PLEASE NOTE REGISTRATIONS & CHANGES CAN TAKE UP TO 14 DAYS TO PROCESS.