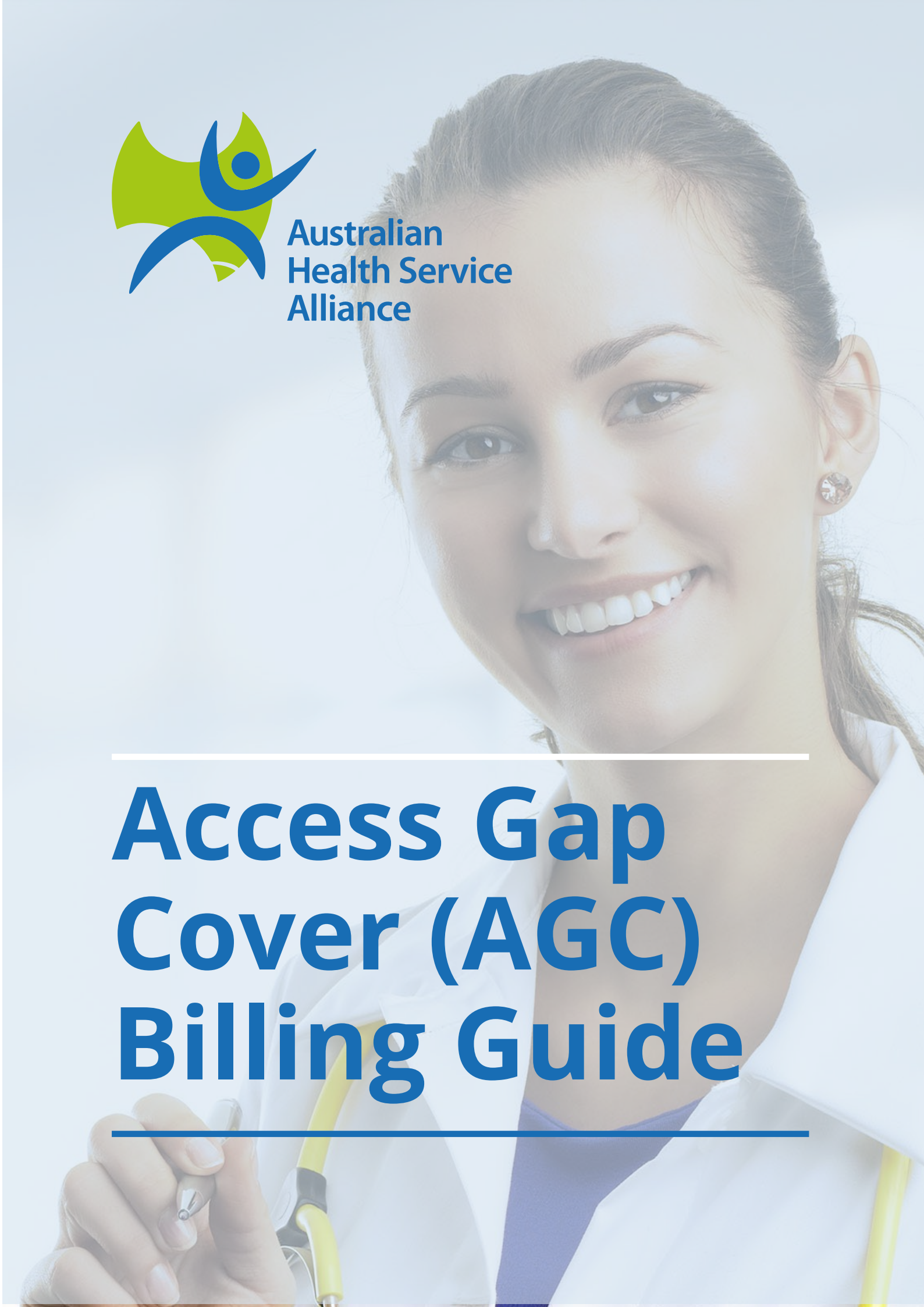


Australian
Health Service
Alliance

Access Gap Cover (AGC) Billing Guide

Contents

What is Access Gap Cover (AGC)?

- AGC is a medical gap cover scheme administered by AHSA and provided by AHSA participating funds.
- It consists of eight state- and territory-based fee schedules. Your provider number (location) determines which fee schedule to use.
- It can be used for admitted patients or patients receiving Hospital-Substitute Treatment.
- You can opt in and out on an episode by episode basis.
- It is a 'no gap' and a 'known gap' scheme (no additional registration required for 'known gap').
- It has defined terms and conditions along with this billing guide which must be adhered to if you wish to participate.
- AGC benefits and the allowable patient co-payment (where the doctor charges a co-payment) are maximum fees only under the terms of AGC and are not prescribed or recommended fees.

What are the benefits for doctors?

- Allows for a 'known gap' of $500 per doctor per episode where written Informed Financial Consent (IFC) has occurred
- Doctors can 'opt in and out' of AGC on an episode by episode basis
- Improved cash flow for doctors – 21-day turnaround (provided account has been received from the hospital and there are no issues with the Medicare claim)
- Reduces bad debts for doctors
- Benefits are paid directly into your nominated bank account
- You do not have to deal with Medicare – the fund will send you the total payment which includes the Medicare and the participating health fund benefit.
- Doctors provide registration and other contact details (e.g. bank details) once for all participating AHSA funds
    - One fee schedule per state or territory for all participating AHSA funds

    - One set of terms and conditions and one billing guide for all participating AHSA funds
- Patient management remains with the doctor – no interference in clinical practice
- AGC fee schedules are reviewed annually
- Access to ECLIPSE billing
- Doctors may withdraw from AGC at any time

What are the benefits for patients?

- Avoids confusion as claiming procedures are managed by their fund
- Can eliminate or reduce patient gaps
- Provides financial certainty with informed financial consent
- Member Statement of Benefit – funds provide a statement back to their member summarising the services the doctor has performed, highlighting the value of private health

What is the maximum patient co-payment (allowable known gap)?

AGC enables you to charge your patients a co-payment if you wish to do so.

- Each individual medical provider[1] in the admitted episode[2] of care can choose to charge their patient a maximum out-of-pocket cost of up to $500 for MBS rebateable items only.
- Obstetricians can choose to charge their patient a maximum out-of-pocket cost of up to $800 per episode for MBS items that relate to 'Management of Labour and Delivery'.

[1] Where an assistant surgeon's fees are claimed together with the surgeon's fees: If a surgeon submits one claim with both their services and the assistant services, the maximum total co-payment for the fund Member for both that claim and the episode cannot exceed $500 if AGC applies. This is because the co-payment rule requires one account per claiming provider and therefore only one co-payment is permissible per claim.

[2] **Episode** means the period of admitted patient care between a formal or statistical admission and a formal or statistical separation.
Example 1: If an admitted patient changes care type (in the same or different Hospital), such as "Acute" to "Rehabilitation", then back to "Acute", this would constitute three separate episodes. This would apply even if there has not been more than a seven-day break between to two acute episodes.
Example 2: If an admitted patient is discharged and comes back within seven days (perhaps due to an infection), it is still considered a new episode for the purposes of the allowable gap.

- Each medical provider must submit one claim only to the fund covering an entire episode, i.e. all MBS services that form part of the episode for that provider (from admission to separation) to be included on a single claim.
- If you are going to charge a co-payment you will need to provide written 'Informed Financial Consent' to the patient. To do this, simply complete the 'Estimate of Medical Fees' form (Attachment 4), or equivalent and give to the patient.
- This amount is to be billed direct to the patient by you.

You are still required to put the total charge on the claim submitted to the fund (inclusive of any patient co-payment) whether submitted manually or via ECLIPSE . If you charge above and beyond the maximum patient co-payment, AGC benefits will not be payable. In this instance, the fund will pay up to the MBS fee only. You cannot on-charge the difference to the patient as the conditions of informed financial consent do not allow this.

If you choose to charge the patient more than AGC allows, then you have the option to opt the patient out of AGC. The patient should be advised about the charges and any medical gaps, i.e. informed financial consent should also form part of this process.

What fees are not allowed?

If you choose to use AGC you must not charge any non-clinical fees to your patient such as administrative charges, admission fees, processing fees, booking fees or reservation fees, technology fees, entertainment levies, insurance levy fees, hospital facility fees or similar amounts.

This includes any hidden fees or fees not being a professional service described by an MBS item number.

Can I charge the patient up-front?

You cannot charge the patient for the total cost of treatment up-front. Only the co-payment can be charged to the patient where written informed financial consent has been provided.

Can I give the bill to the patient and still expect AGC benefits to be paid?

You cannot give the bill to the patient to take to the Fund (paid or unpaid). If you choose to use AGC, you will need to submit the unpaid claim to the health Fund on behalf of your patient.

How do I participate in AGC?

Step 1	Complete the 'Provider Details & Direct Credit Authority' form *Attachments 3 and 3A*
Step 2	Submit your completed form(s) to AHSA via email access@ahsa.com.au or fax on 1800 670 898
Step 3	A letter of confirmation will be emailed to you by AHSA
Step 4	You can then start billing under AGC – send your claims to individual funds *Refer to the AHSA Participating Funds Contact List*

Please note: Doctors must make their own independent decisions as to whether and to what extent they participate in AGC, and also as to the level at which they set their fees.

Claiming under AGC

How do I claim under AGC?

Step 1

- Identify patient as a member of an AHSA participating fund
  Refer to the AHSA Participating Funds Contact List for AGC

Step 2

- Establish patient eligibility
  Refer to further details under Step 2 on the following page.

Step 3

- If you are going to charge a co-payment you will need to provide written informed financial consent to the patient. To do this, simply complete the 'Estimate of Medical Fees' form (or eqivalent) and give to the patient.
  Attachment 4

Step 4

- Claims should be submitted electronically via ECLIPSE.

- **If you do not use ECLIPSE:**
- Complete AHSA 'Doctor Account' form or equivalent
  Attachment 2
- Attach 'Account Summary Form'
  Attachment 1
- Send your claims to individual funds
  Refer to the AHSA Participating Funds Contact List for AGC

Step 5

- Receive payment for services rendered within 21 days of billing the fund (where certain conditions are met - refer to the AGC terms and conditions)

What happens if a patient is referred to me for hospital treatment?

Step 1: Determine private patient status and fund details

1. Ask the patient whether they are being treated as a private patient.
2. If yes, ask the patient whether they will be using private health Insurance.
3. If so, obtain their Medicare number (including the one-digit patient reference number).
4. Determine which AHSA participating fund the patient belongs to and obtain their membership number.

Step 2: Establish patient eligibility

1. To confirm patient eligibility and membership level of cover please contact the appropriate AHSA participating fund.
2. What patient details do you need to confirm with the fund?
    - The patient is a member of a fund that belongs to AHSA and the fund participates in AGC.
    - The product that the patient has purchased is eligible for AGC.
    - The procedure is covered by the member's policy (i.e. not an exclusion).
    - The patient's membership is financial.
    - Waiting periods and benefit limitation periods have been served.
    - The services are not compensable.
3. The following information will provide you with everything else you need to know about patient eligibility and membership level of cover.

Application to all hospital products

- Some funds have elected to restrict AGC benefits on some of their hospital products.
- Always refer to the AHSA Participating Funds Contact List for AGC to confirm.

Application to exclusion products

- Where a health fund product has an exclusion clause(s), the relevant procedure may be excluded from benefits.

Application to all excess products

- Where a health fund product includes a front-end deductible or excess, the relevant amount will not apply to the medical gap benefits that would be payable under AGC.

Waiting periods

- The following waiting periods apply to all new members (if they were previously uninsured).
  - A waiting period of up to 12 months exists for all obstetric-related services (dependent upon the particular fund); and
  - A 12-month waiting period on all pre-existing ailments.
- These waiting periods may also apply when a member changes their level of cover or transfers their membership from one fund to another.

The best way to be sure that your patient is eligible for benefits under AGC is to contact the relevant fund and check their eligibility. Refer to the AHSA Participating Funds Contact List for AGC to enable eligibility and membership level of cover checks.

The AGC fee schedule shall apply only to those services that are provided by you to eligible fund members.

What types of services are eligible under AGC?

1. Medical services rendered to an admitted patient during an episode of hospitalisation
2. Medical services provided under an approved Hospital in the Home (HITH) program
3. Medical services rendered to the patient where they fit the criteria for Hospital-Substitute Treatment (H-ST)

Legislation does not allow private health funds to pay for medical services unless they fit into one of these three categories.

Any medical consultations or treatments prior to or after hospitalisation, HITH and/or H-ST are not claimable under AGC. Remember to inform the patient that these medical services are claimable through Medicare only.

Under what circumstances are benefits not payable?

Funds will not pay an Access Gap Cover medical benefit:

- If the service was not performed whilst an admitted patient of a recognised hospital and/or does not fit the criteria for Hospital-Substitute Treatment (H-ST);
- Where you charge the patient more than a $500 gap per episode (or more than $800 if you are an obstetrician);*
- Where you charge non-clinical fees to your patient, including administrative charges, admission fees, processing fees, booking fees or reservation fees, technology fees, entertainment levies, insurance levy fees, hospital facility fees or similar amounts. This includes any hidden fees or fees not being a professional service described by an MBS item number;*
- Where you charge a gap and the patient was not provided with written IFC; i.e. you did not tell them about the gap in writing*
- If the account is not sent directly to the fund by the provider;*
- If the account has been fully paid by the patient prior to claiming from the fund;*
- If the membership was un-financial at the time of treatment or service;
- If the claim was covered by workers compensation, third party or is compensable from elsewhere;
- Where waiting periods have not been served;
- Where the fund product excludes benefits for specific treatments and procedures;
- Where a Medicare benefit is not payable or where Medicare has rejected the claim;
- Where the claim has not been lodged within two years of the date of service (some funds have shorter timeframes);
- If the member was admitted to a public hospital as a public patient;
- If the MBS item is an uncertified Type C Procedure and therefore does not form part of Hospital Treatment. 'Hospital Treatment', specifically 'excluded treatment', is defined in

the Private Health Insurance (Health Insurance Business) Rules (as updated). The excluded treatments outlined (a) are those treatments listed in clause 8 of Schedule 3 of the Private Health Insurance (Benefits Requirements) Rules (as updated), namely the Type C Procedures;

- Where the patient is not on a product eligible for medical gap cover scheme benefits;*
- Where you have billed the patient directly and they have collected their Medicare entitlement;*
- Where the particular provider number of a doctor is salaried at a public hospital;*
- Where the date of service of the claim is prior to three months from the date of AGC registration.*

*** NB:** Funds will not pay the AGC benefit in this situation. The maximum a fund can pay is the standard 25% of the MBS Fee.

Please note: This list provides an indication using examples only and is not exhaustive, e.g. some funds will not provide a benefit for cosmetic surgery. Some funds will not pay a benefit for surgery performed by a surgical podiatrist. Please refer to the AGC terms and conditions for further details on AGC rules or contact the fund for member eligibility advice.

Step 3: Make proper disclosure to the patient — Informed Financial Consent (IFC)

Written IFC is required under AGC if you are charging a gap to the patient.

1. It is crucial that your patients are correctly informed of their out-of-pocket expenses.
2. You can use the 'Estimate of Medical Fees' form (Attachment 4) for this purpose or you can use your own method of written IFC. If you use your own method, please ensure that it includes all relevant information about the patient and the procedure as well as details about any patient gaps. The patient and/or the guardian will also need to sign the form or letter to indicate acceptance.
3. The form or letter should be given to the patient prior to the procedure where practicable, before the time of admission to the hospital or day facility for the treatment in question, or otherwise, as soon as the circumstances reasonably permit.
4. Although you are not required to send a copy to the health fund, you are required to indicate on the claim to the fund that this has been done. Please use the tick boxes as shown on the 'Account Summary' form for this purpose. (Attachment 1)

5. If you use ECLIPSE to submit claims, the IFC field should be set to X for scheme (SC) type claims where there is no gap. Where there is a gap and the member has been provided with written IFC for a known gap, the IFC field must be set to W.

6. Where AGC benefits have not been paid by the fund due to non-compliant billing by the provider, the provider must not seek reimbursement from the member as IFC would already have been agreed in writing. Only out-of-pocket expenses already agreed may be raised to the member.

Financial disclosure

AGC also requires that you disclose any financial interests in products or services recommended or given to the patient.

Step 4: Submit your claim to the individual fund (not AHSA)

1. Claims should be submitted electronically via ECLIPSE. Refer to this link for more information about ECLIPSE.
2. If you need to submit a manual claim, complete the 'Account Summary' form (Attachment 1). This form acts as a batch header and should be completed each time you send a batch of claims to a fund.
3. Then complete the 'Doctor Account' form (Attachment 2). Alternatively, you can use your own account form provided it includes all the details on the Doctor Account form.
4. Do not include more than 20 accounts in one batch to a particular fund.
5. **Do not send claims to AHSA.** Refer to the AHSA Participating Funds Contact List for AGC.
6. When the fund receives your account – each fund will validate this data and forward it to Medicare for processing. Medicare will process the claims and pay 75% of the MBS fee to the fund.
7. The fund will raise a payment for you that covers the Medicare benefit (75% of the MBS fee) and the remainder of the charge up to the AGC fee schedule benefit.
8. You will be notified of all approvals and rejections.

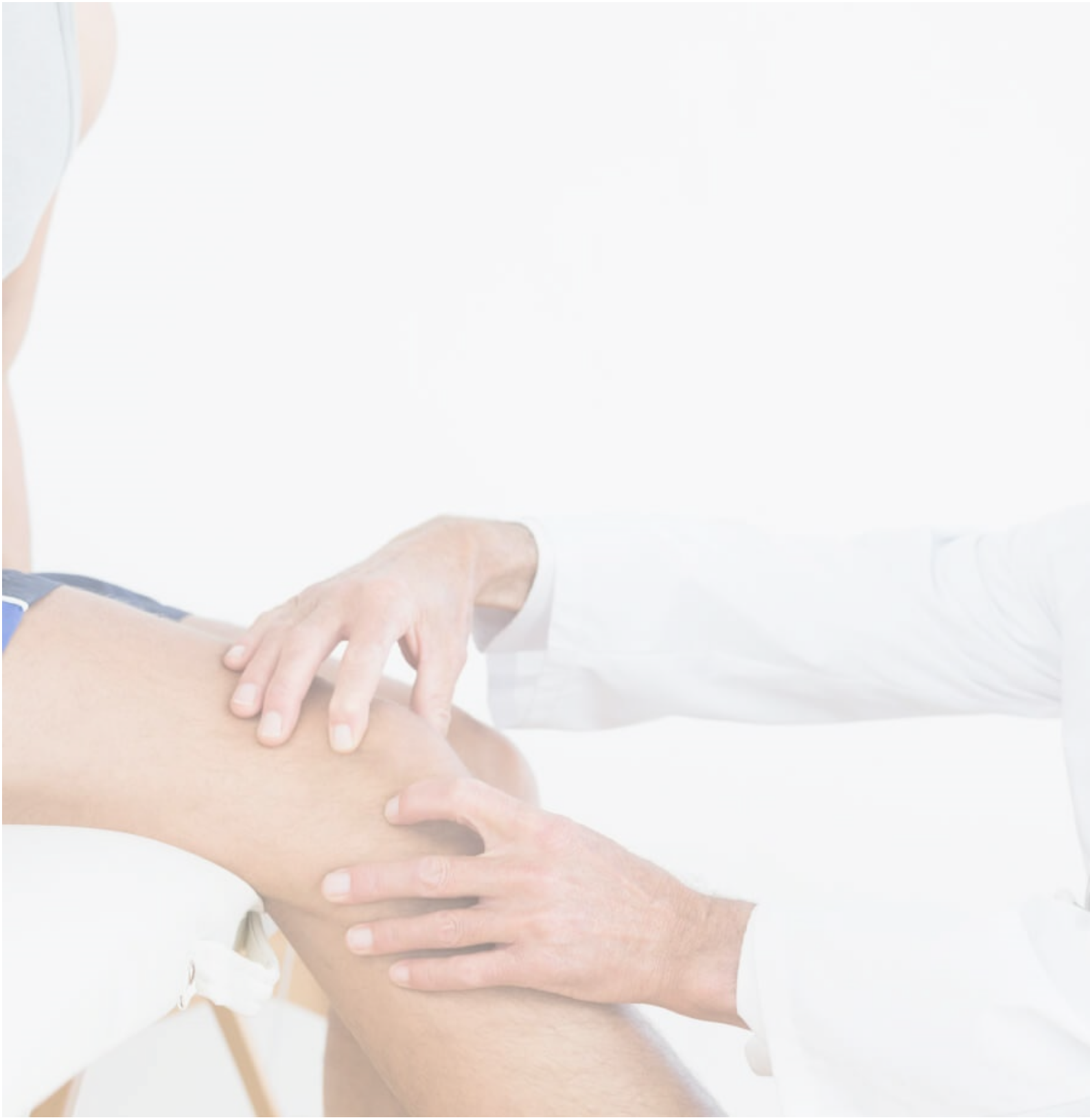
9. As there are unique computer systems across the participating AHSA member funds, there will be different versions of the Medical Claims Summary Report, however, the information contained in each will be the same.
10. Any fund/Medicare explanations/rejections (depending on explanation code) need to be either re-submitted to the appropriate fund for processing or sent to the member for payment.
11. All AGC claims must be submitted directly to the health fund by the provider. AGC benefits will not be payable on claims submitted by the member. Where a member submits a medical claim directly to the health fund, benefits will be paid up to the MBS fee only.
12. Once a medical claim has been submitted to the health fund, the provider must not contact the patient in relation to the billing process unless there is an out-of-pocket expense agreed through written informed financial consent.
13. All AGC forms may be downloaded from the AHSA website: www.ahsa.com.au
    Go to 'For Doctors', then 'AGC Forms' or use this link: AGC forms.

Step 5: Receive payment for services rendered

1. Payments will be deposited directly into your nominated bank account.
2. The fund will pay a valid claim within 21 days after receipt by the fund, subject to each of the following requirements being satisfied:
    - the relevant Medicare rebates have been received in full by the fund;
    - the fund has received the associated hospital claim (which may be required to verify the fund member's admitted status);
    - the fund member is an eligible fund member for the purposes of the claim; and
    - the fund not requiring any further information from the provider in relation to the claim, including information that is required to determine whether the claim is a valid claim.

    Claims may be delayed or rejected if subject to any of these conditions. Payment times may be faster if you use ECLIPSE.
3. Patients will receive a statement of benefit verifying that the service was performed and that a benefit payment has been made.
4. If you raise a charge that is not in accordance with the AGC terms and conditions and this billing guide, the fund will not be obligated to pay your account. In these

circumstances, the fund may seek an amended account from you. Where an account is submitted under AGC and the charges are above and beyond the maximum patient co-payment (allowable known gap), the fund is only obliged to pay benefits up to the MBS fee. AGC benefits will not be paid in this instance.



How are benefit payments calculated?

How does the Access Gap Cover fee schedule work?

The fee schedule will provide:

- A dollar benefit against each MBS item number. This dollar benefit includes both the MBS benefit and the additional AGC benefit or
- A percentage benefit. Apply the percentage to the MBS fee of the applicable MBS item.

AGC benefits and the allowable patient co-payment are maximum fees only under the terms of AGC and are not prescribed or recommended fees. Doctors must make their own independent decisions as to whether and to what extent they participate in AGC and also as to the level at which they set their fees.

How does Medicare's assessment of the MBS relate to Access Gap Cover?

As AGC is based on the MBS, the normal Medicare claims assessing rules prevail, prior to the determination of any benefits that the fund will pay that exceed the MBS.

The assessment of the Medicare benefit will continue to be conducted by Medicare and the fund will rely on that assessment to determine the level of fund benefits that are payable under AGC.

What rules apply for derived fee items?

All derived fee items will be displayed as a percentage benefit under AGC. The AGC benefit payable (including the Medicare component) will be determined by using the appropriate MBS fee (indicated by Medicare) multiplied by the AHSA percentage benefit.

For example: Where the assistant surgeon uses MBS item 51303 – apply the AHSA percentage benefit for item 51303 to the MBS fee for the applicable operation and divide by five.

What rules apply for multiple operations?

Multiple operations will be calculated using Medicare rules. Use the MBS fee to determine the order for multiple operations (do not use the AHSA benefit to order your items). Benefits however will be calculated by applying the appropriate percentages to the AGC benefit payable (including the Medicare component) i.e. 100%, 50% and 25% thereafter.

What rules apply for multiple anaesthesia services?

Where anaesthesia is provided for services covered by multiple items in the Relative Value Guide (RVG), Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services.

What happens if Medicare introduces other multiple procedure rules?

From time to time Medicare may introduce further multiple procedure rules, e.g. Multiple Vascular Ultrasound Services Site Rule. Medicare rules prevail in all instances.

What rules apply for diagnostic imaging services?

All diagnostic imaging services will be displayed as a percentage. The AHSA benefit payable is calculated (including the Medicare component) as follows:

- Under normal conditions (when Rule A, B or C do not apply) multiply the AHSA quoted percentage by the MBS fee.
- When any combination of Rule A, B and C apply, multiply the AHSA quoted percentage by the Medicare adjusted MBS fee.

What rules apply for assistance at operations?

Where the surgeon is participating in AGC and the assistant is not: Where the assistant's services appear on the same account as the surgeon's, the assistant will be paid the AGC benefit even if they are not participating in the AGC arrangement. Medicare should not reject the claim. The total amount will be made payable to the surgeon under his/her provider number. The allocation of the total payment is a matter to be resolved between the surgeon and the assistant.

Where the assistant bills separately he/she will be required to participate in the AGC arrangement in his/her own right to receive the AGC benefit. The allowable AGC co-payment will also be available to the assistant where they bill separately. Where the assistant does not wish to participate, the claim should not be processed according to AGC.

If the surgeon submits one account with both his/her services as well as the assistant services, the total out-of-pocket gap for the member for the entire account cannot exceed $500 to be eligible for AGC. This is because the co-payment rule requires one account per claiming provider and therefore only one co-payment is permissible per claim.

What rules apply for locums?

Where a locum carries out a service for a doctor who is registered under AGC, and the locum uses the same practice provider number as the usual doctor, the fund will pay the AGC fees for the locum services. If the locum uses their own provider number and has not registered with AGC, payment will be made up to MBS fee only. The latter should not be processed according to AGC.

What rules apply for Hospital-Substitute Treatment (H-ST)?

AGC can also be utilised for H-ST. Services must fit the criteria for H-ST according to the Act and supporting rules.

Doctors providing H-ST services should ask the patient if they want to use their private health insurance or claim from Medicare only. If they wish to use their private health insurance, please indicate on the account that the services form part of H-ST.

Please ensure that the words 'Hospital-Substitute Treatment' are written on the account as required by the Health Insurance Regulations 1975 as amended.

What rounding policy applies?

No rounding is required under AGC. The charge per MBS item should be the AGC fee. For calculations involving derived fees, multiple procedures and/or diagnostics, it may be necessary to round the TOTAL to the nearest cent.

To be specific, rounding to the nearest cent will involve rounding to two decimal places. Where the third decimal value is five or greater: round UP to the nearest cent. Where the third decimal place is less than five: round DOWN to the nearest cent.
For example:

- $200.445 will round UP to $200.45
- $200.832 will round DOWN to $200.83

Frequently asked questions

Who is Australian Health Service Alliance (AHSA), and what does AHSA do?	AHSA represents a number of private health funds across Australia and is responsible for facilitating payment arrangements between hospitals, doctors and health service providers on behalf of these funds. Click on this link for a list of funds who participate in AGC: AGC Participating Funds Contact List.
Can I charge a co-payment?	Yes, however you cannot charge the patient more than $500 per episode (up to $800 for obstetricians). Written 'informed financial consent' must also be provided to your patient. If you wish to participate in AGC, you cannot charge any additional fees to the patient including administrative charges, admission fees, processing fees, booking fees or reservation fees, technology fees, entertainment levies, insurance levy fees, hospital facility fees or similar amounts. This includes any hidden fees or fees not being a professional service described by an MBS item number.
How do I participate?	Simply fill out the Provider Details & Direct Credit Authority form (Attachment 3) and fax or email to AHSA who will distribute the information to all participating AHSA funds. This process will save time, as you will only have to provide your details once for all participating AHSA funds.
Can I give the AGC claim directly to my patient to take to their health fund?	No. If you choose to participate in AGC, all AGC claims must be submitted directly to the patient's health fund.
Can I charge the full amount to my patient up-front prior to claiming from the health fund?	No. If you choose to participate in AGC, you can only ask the patient to pay the gap amount up-front, if there is a gap. Only unpaid AGC accounts can be submitted to the health fund. You are still required to put the total charge on the account to the fund (inclusive of any patient co-payment).
How will this affect my relationship with my patients?	The autonomous relationship between you and your patients will not be affected in any way. The AHSA and participating funds acknowledge that you exercise your own clinical

	judgement at all times in the provision of services to your patients.
When should I provide written informed financial consent?	When there is a patient gap – use the Estimate of Medical Fees form (Attachment 4) or equivalent. It is crucial that your patients are correctly informed of their out-of-pocket expenses.
What if I no longer want to participate in AGC?	There is an opt-in, opt-out facility, so you do not have to do anything to cease participation. Simply do not use AGC where you don't want to. Alternatively, you can contact AHSA to cease participation altogether.
When will my benefits be reviewed?	The AGC fee schedule will be reviewed annually. Where indexation is applied, it will be applied to the benefit above MBS. It will generally reflect the Australian Medical Association (AMA) Medical Fee Index (MFI) that is calculated annually for the various peer groups defined by the AMA, another index or a nominated amount determined by AHSA. The application, timing and level of indexation (and whether any indexation is applicable at all) will be determined at AHSA's absolute discretion.
What happens with my information?	As AGC is administered by AHSA, all of its participating funds will be notified of your registration, even if you bill only some funds. AHSA collects, stores and passes on your bank details to participating funds for the purposes of allowing AGC payments to be made to you. For more information about privacy, go to the following link: Privacy
Do special rules apply for salaried doctors at public hospitals?	Salaried Doctors at public hospitals may register for AGC and access simplified billing but will be reimbursed at MBS fee only.
How will AHSA contact you?	All correspondence from AHSA will be sent via the email address you supplied under 'Email address for AHSA Correspondence' on the registration form.

	This email address will not be used by funds for claims reconciliation unless you have specifically requested this or unless a particular fund has asked for your permission and you have agreed.
What if my contact details change?	Please notify AHSA of any change of address, email or other details. You do not need to notify participating funds individually.
Why should I use the AHSA fee schedule?	AGC will help to restore the full value of private cover by offering greater certainty to patients and enhancing the role of private health. It is a widely accepted fact that exposure to uninsured medical gaps is one of the major reasons people leave private health insurance following an episode of care. Gaps also deter non-members who might otherwise obtain private cover.
What are the most important pieces of information I need to collect?	For the billing process to run smoothly and the health fund to claim from Medicare on behalf of your patient, you must clearly provide the Medicare number and the one-digit patient reference number with your claim. It is also important to obtain your patient's private health fund membership number.

IMPORTANT LEGAL INFORMATION

The terms and conditions that apply to AGC are set out in the "Agreement". The Agreement consists of this Billing Guide, the Terms and Conditions and the AGC Fee Schedules (current versions of which can be viewed here. (Or go to the AHSA website www.ahsa.com.au - click on 'For Doctors' and then 'Access Gap Cover')

Under the terms of the Agreement, AHSA may vary the Agreement from time to time. If you submit an AGC claim after AHSA has given notice of variation under the Agreement, this means that you have irrevocably consented to that variation.

If there is any inconsistency under the Agreement, the terms and conditions set out in Terms and Conditions take priority, followed by the terms and conditions set out in the Billing Guide, followed by the AGC Fee Schedules and then any other documents or information annexed to the Billing Guide or incorporated by reference into the Agreement.

By registering for and participating in the AGC scheme, you agree that you have read and understood the Agreement and will comply with it, and will direct your billing staff to comply with the Agreement.

Capitalised words in this section entitled 'Important legal information' are defined in the Terms and Conditions.

Attachments

ATTACHMENT 1	**Account Summary form** (Batch Header)
ATTACHMENT 2	**Doctor Account form**
ATTACHMENT 3	**Provider Details & Direct Credit Authority form** (including additional practice locations)
ATTACHMENT 4	**Change of Registration Details form**
ATTACHMENT 5	**Estimate of Medical Fees form** (Photocopy onto your letterhead)

All AGC forms may be downloaded from the AHSA website: www.ahsa.com.au
Go to For Doctors, then AGC Forms or use this link: AGC forms

HOW TO USE THE ACCOUNT SUMMARY FORM

If you do not use ECLIPSE, an AGC Account Summary form must accompany all medical claims that are sent by you directly to the participating fund.

WHY IS THE ACCOUNT SUMMARY FORM REQUIRED?

1. It allows the fund to recognise the claim as an AGC claim.
2. It will summarise the number and amount of accounts you submit.
3. The Account Summary form number will assist you to track and reconcile the weekly or fortnightly submission of claims.
4. It provides a comment field for your administration staff to note any general information pertaining to the accounts.
5. It includes a declaration that these services were provided to a patient receiving hospital treatment either accommodated within a hospital or under an approved Hospital in the Home Program or the services form part of Hospital-Substitute Treatment.
6. It also includes the following declarations:
    - That the total amount charged is shown on the account/s to the fund, including any patient co-payments.
    - That co-payments are within the allowable limits according to the AGC terms and conditions.
    - That booking fees and the like have not been charged to the patient/s.

HOW IS THE ACCOUNT SUMMARY FORM USED?

- All fields on the form must be completed, with the exception of the comments.
- The majority of the fields are self-explanatory, however, the following may assist:

Account Summary Number

This is the date the batch of accounts leaves the provider's rooms, with an alpha character signifying the order of bundles for that day.

For example: if multiple batches are sent on 17 April 2021

Batch 1 = 17042021A
Batch 2 = 17042021B
Batch 3 = 17042021C

It is important that this number is unique per batch, as this number combined with your provider number will enable the fund to identify your batches.

If you have a query with one of your batches, you need to quote the Account Summary number together with your provider number, to enable the fund to locate it quickly.

Total Fee Charged

This is the total fee charged for all claims submitted in the batch. The fund will use this figure to reconcile that the assessor has entered all claims for that batch.

Total Number of Accounts

This is the total number of accounts submitted in the batch. Please remember that the number of accounts submitted per batch cannot exceed 20.

Total Amount Claimable

This is the total amount you are expecting to claim back from the fund once the claims have been assessed.

The fund will provide you with a Medical Claims Summary Report, which will total both the amounts of claims approved for payment and the rejections.

This total should equal your total amount claimable and will assist you in reconciling claims payments.

Comments

Your administration staff can note general comments pertaining to the batch. The fund assessors may also do the same.

Any comments entered by fund staff will be for internal purposes only.

ACCOUNT SUMMARY FORM

ATTACHMENT 1

Access Gap Cover

1. Health Fund Details

Health Fund Name

Health Fund Address | State | Postcode

The medical practice has explained the billing process to the patient and the patient is fully aware of any co-payments charged.

2. Provider Details

Provider's Name

Provider Number | Telephone Number

( )

3. Batch Details

Account Summary Number (optional reference number) - Refer to explanation in the Billing Guide at Attachment 1. | Date

Total Fee Charged (including Gap) | Total Number of Claims | Total Amount Claimable

$ | $

4. Declaration

The professional services specified on the attached forms were provided by me or on my behalf.

The total amount charged is shown on the attached account/s to the fund, including any patient co-payments. Co-payments are within the allowable limits according to the Access Gap Cover Terms and Conditions and booking fees and the like have not been charged to the patient/s.

These services were performed whilst an admitted patient of a recognized hospital or day facility and/or the services form part of Hospital-Substitute Treatment.

All services in this batch are 'No Gap', i.e. the patient/s has nothing to pay ☐ Yes ☐ No, some or all services have a Gap

I have provided the patient/s with an 'Estimate of Medical Fees' form ☐ Yes ☐ No

I have disclosed any financial interests in the management of this patient/s ☐ Yes ☐ N/A

Signature | **Date**

May be signed by the provider or billing staff

5. Comments

IMPORTANT NOTICE

PLEASE SEND CLAIMS TO THE PATIENTS HEALTH FUND (NOT TO AHSA)

Refer to the AHSA Participating Funds Contact List at www.ahsa.com.au/doctors

This form may be photocopied

HOW TO USE THE DOCTOR ACCOUNT FORM

- All fields on the Doctor Account form need to be completed.
- Both Medicare and the fund use the information on this form to assess medical claims.
- Completed account forms are collated into batches (20 max) and forwarded to the appropriate fund with an Account Summary form.

The majority of fields on this form are self-explanatory, however the following may assist:

Health Fund Name
Please indicate which participating health fund the patient belongs to.

Membership Number
The fund membership number MUST be provided. This information can be obtained from the patient or by contacting the appropriate participating fund directly.

Dependant Suffix
The dependant suffix is used by the fund to identify which dependant on the membership the claim is for. Only enter this information if known.

Patient Account Reference
(Invoice or account number)
The patient reference is assigned by you and should match your patient's accounting record. The fund records this information as part of the claim. This will enable the fund to quote your patient account (claim) reference on the payment summary report for reconciliation.

Facility at which the Service was provided
The name and provider number of the hospital or approved day care facility MUST be entered in this field. Any claims submitted without this information will be rejected.

If the services were performed as part of Hospital-Substitute Treatment, the name of the substitute care service provider MUST be entered in this field. Any claims submitted without this information will be rejected.

Patient Reference Number
The patient reference number is a single character number found alongside a dependant on the Medicare card. This number is used to identify the person the claim is for.

The Medicare reference number must be supplied wherever possible; otherwise Medicare may not be able to process the claim or the claim may be delayed.

H-ST – Hospital-Substitute Treatment
Please indicate by placing a tick against the appropriate services if they form part of H-ST.

Applicable Service Conditions
Applicable service conditions are special Medicare requirements. Medicare requires certain information relating to these specific situations. Please ensure the information submitted on your account meets all Medicare requirements. Some of these conditions may not relate to your area of specialty. Please refer to the MBS for further information.

Comments
The comments section is supplied to enable you to add or supply any supporting information you feel is necessary regarding that claim.

Please note:
Where your accounts include all details required on the AGC Doctor Account form, you can attach your accounts to the completed AGC Account Summary form rather than completing the AGC Doctor Account form.

All AGC forms may be downloaded from the AHSA website, which is: www.ahsa.com.au
Go to For Doctors, then AGC Forms.

DOCTOR ACCOUNT FORM

ATTACHMENT 2

Access Gap Cover

1. Practice Details

Practice Name

Provider's Name / Provider Number

2. Doctor Account Details

Patient Account Reference

Patient's Name | Date of Birth

Patient's Address | State | Postcode

Health Fund Name | Membership Number | Dependant Suffix

Facility at which the service was provided | Patient's Medicare Number | Patient Reference No | Valid to

MBS Item Number	Description of Service	Number of Patients Seen	Date of Service	Provider Number	Charge	Patient Co-Payment Amount	H-ST*
					$	$	
					$	$	
					$	$	
					$	$	
					$	$	
				TOTAL	$	$	

* Please tick if the service forms part of Hospital-Substitute Treatment (H-ST)

3. Request/Referral Details

Date | Referral Period

☐ 3 months ☐ 6 months ☐ 12 months ☐ 18 months ☐ Indefinite

Provider Name | Provider Number

Address | State | Postcode

4. Applicable Service Conditions

Compensation Related	❑ Yes	❑ No	Considered 'not for comparison'?	❑ Yes	❑ No
Part of a multiple procedure?	❑ Yes	❑ No	Self determined?	❑ Yes	❑ No
Referred within a hospital?	❑ Yes	❑ No	Performed on separate sites	❑ Yes	❑ No
Designated 'not normal' aftercare?	❑ Yes	❑ No	AM/PM?	❑ Yes	❑ No

5. Comments

IMPORTANT NOTICE

PLEASE SEND CLAIMS TO THE PATIENTS HEALTH FUND (NOT TO AHSA)

Refer to the AHSA Participating Funds Contact List at www.ahsa.com.au/doctors

CLAIMS AND PAYMENT REPORT

Your Medical Practice will receive the following report from the fund, which will assist with the reconciliation of submitted batches of claims.

Please note that Australian Unity will only provide electronic remittance advice, either via the ECLIPSE system or the Australian Unity self service portal. Please contact Australian Unity on 1800 035 360 or email providerservices@australianunity.com.au if you require further information.

THE MEDICAL CLAIMS SUMMARY REPORT

- This report will be sent to your practice after a claim or batch of claims has been lodged with Medicare for assessment and payment.
- The report outlines whether a claim or batch of claims have been approved or rejected.
- The total benefit paid will be forwarded to the practice via direct credit, in conjunction with this report.

Fields on this report include:

Practice Reference
This is the Account Summary number under which the claims were submitted.

Provider Number
The location-specific Medicare number of the provider who performed the service.

Patient Reference
Your patient account reference.

Item Number
MBS item number of the service performed.

Service Date
Date the service was performed.

Amount Charged
Amount charged per item.

Benefit Paid
Benefit amount paid.

Explanation Code
Three-digit explanation code.

Description
This field includes the fund's reference and the Account Summary number.

Amount
Payment amount or total payment amount per batch.

Direct Credit Details
If the payment was made by Direct Credit, the transaction number and the date will be indicated here.

STATEMENT OF BENEFIT FOR THE MEMBER

The fund will also provide the member with a statement of benefit outlining the payment made as well as any rejections.

- The statement of benefit for the member is an important part of the AGC process as it outlines the amount of money funds have paid on their behalf and therefore reinforces the value of private health insurance to fund members.
- The following standard explanation will be included on all statements of benefit that are sent to members to clarify that it is for their information only and no further action is required.

THIS IS NOT A BILL
This statement is for your records only and outlines benefits paid on your behalf. If there is any additional co-payment your doctor should have already advised you and will bill you separately.

CLAIM REJECTIONS

Your claim may be rejected by either Medicare or a private health fund. When this happens, a reason code and an explanation will be provided to you.

By completing some checks before you lodge claims or making sure you provide all the information needed to assess claims, you can reduce the likelihood of claim rejections.

Medicare may reject claims for the following reasons:

- an incorrect MBS item being used
- the patient having received the maximum allowable number of benefits for an MBS item
- issues with patient or health professional eligibility
- further information being required to assess the claim

Please note that this list provides an indication using examples only and is not exhaustive.

When claims are rejected, a Medicare reason code provides a brief explanation or reason for the rejection. Generally, this information can be used to:

1. Identify any claiming errors
2. Make any corrections
3. Resubmit for payment

Medicare reason codes are three-digit codes found in processing reports and Medicare benefit statements. View the Medicare reason codes list.

Individual funds may reject claims for the reasons listed under the heading ‘Under what circumstances are benefits not payable.’ (Included in this Billing Guide)

REQUIREMENTS FOR THE REGISTRATION FORMS

PROVIDER DETAILS & DIRECT CREDIT AUTHORITY FORM (ATTACHMENT 3)

CHECKLIST

- ❑ All fields have been completed on page 1 (and on page 2 where required).
- ❑ The mobile number and email address in Part 1 belong to the Doctor.

  (This is important so that AHSA can authenticate and confirm 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 and time stamp
  - 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.

CHANGE OF REGISTRATION DETAILS FORM (ATTACHMENT 4)

CHECKLIST

- ❑ All fields have been completed. (If changes are not required, please tick the 'No change required' box).
- ❑ The Practitioner's email and mobile number at the top of the form belongs to the Doctor.

  (This is important so that AHSA can authenticate and confirm 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.

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.

ATTACHMENT 3 (Page 1)

Part 1 : Practitioner Details

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

Practitioner Telephone

Practitioner Mobile *

Practitioner E-mail *

AHPRA number(s)

Medical Specialty(s)

* The mobile phone number and e-mail address (which must belong to the practitioner), may be used by AHSA to authenticate and confirm 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 and time stamp.
  - 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

Provider Number

Practice Address (Street Address)

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

Suburb | State | Postcode

Practice Telephone | Practice Fax

2nd Additional Practice Location

Provider Number

Practice Address (Street Address)

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

Suburb | State | Postcode

Practice Telephone | Practice Fax

3rd Additional Practice Location

Provider Number

Practice Address (Street Address)

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

Suburb | State | Postcode

Practice Telephone | Practice Fax

4th Additional Practice Location

Provider Number

Practice Address (Street Address)

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

Suburb | State | Postcode

Practice Telephone | Practice Fax

5th Additional Practice Location

Provider Number

Practice Address (Street Address)

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

Suburb | State | Postcode

Practice Telephone | Practice Fax

6th Additional Practice Location

Provider Number

Practice Address (Street Address)

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

Suburb | State | Postcode

Practice Telephone | 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 and time stamp.
  - 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

Australian Health Service Alliance

Access Gap Cover

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 to register new provider numbers.

Practitioner's Name: _____

Practitioner's Email * : _____ Mobile * : _____

* The mobile phone number and e-mail address (which must belong to the practitioner), may be used by AHSA to authenticate and confirm 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.

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.

CHANGE OF REGISTRATION DETAILS FORM

CHECKLIST

- ❑ All fields have been completed. (If changes are not required, please tick the 'No change required' box).
- ❑ The Practitioner's email and mobile number at the top of the form belongs to the Doctor.

  (This is important so that AHSA can authenticate and confirm 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.

ESTIMATE OF MEDICAL FEES

Estimate of Medical Fees

As a service to our patients, we provide the following estimate of the likely medical costs you will be required to pay for your procedure. You should discuss these costs with the doctor or doctor's staff, preferably before your procedure.

Please note that it is an estimate only. Unless specified, the estimate refers only to the fees charged by this practice. It does not cover services provided by other doctors, including radiologists, nuclear physicians and pathologists, nor other costs associated with your episode e.g. accommodation facility, pharmacy and physiotherapy.

In the event of unforeseen circumstances, it may be necessary to arrange additional medical services, resulting in further charges to you.

Patient's Details

Patient's Name

Patient's Address **State** **Postcode**

Health Fund Name **Hospital** **Date of Admission**

Procedure Details

Item Number(s)/Description of Service(s)	Fee	Total benefits (Medicare/Health Fund Benefit) – (see Note 1) (optional)	Patient Gap Payment – (see Note 2) (optional)

You are likely to have a gap to pay ❑ Yes ❑ No *If yes, please refer to your Health Fund for additional information not provided above.*

❑ Pathology and ❑ Radiology services are likely to be required during your episode of care.

Any financial interests in products or services recommended or given to the patient have been disclosed to the patient. ❑ Yes ❑ N/A

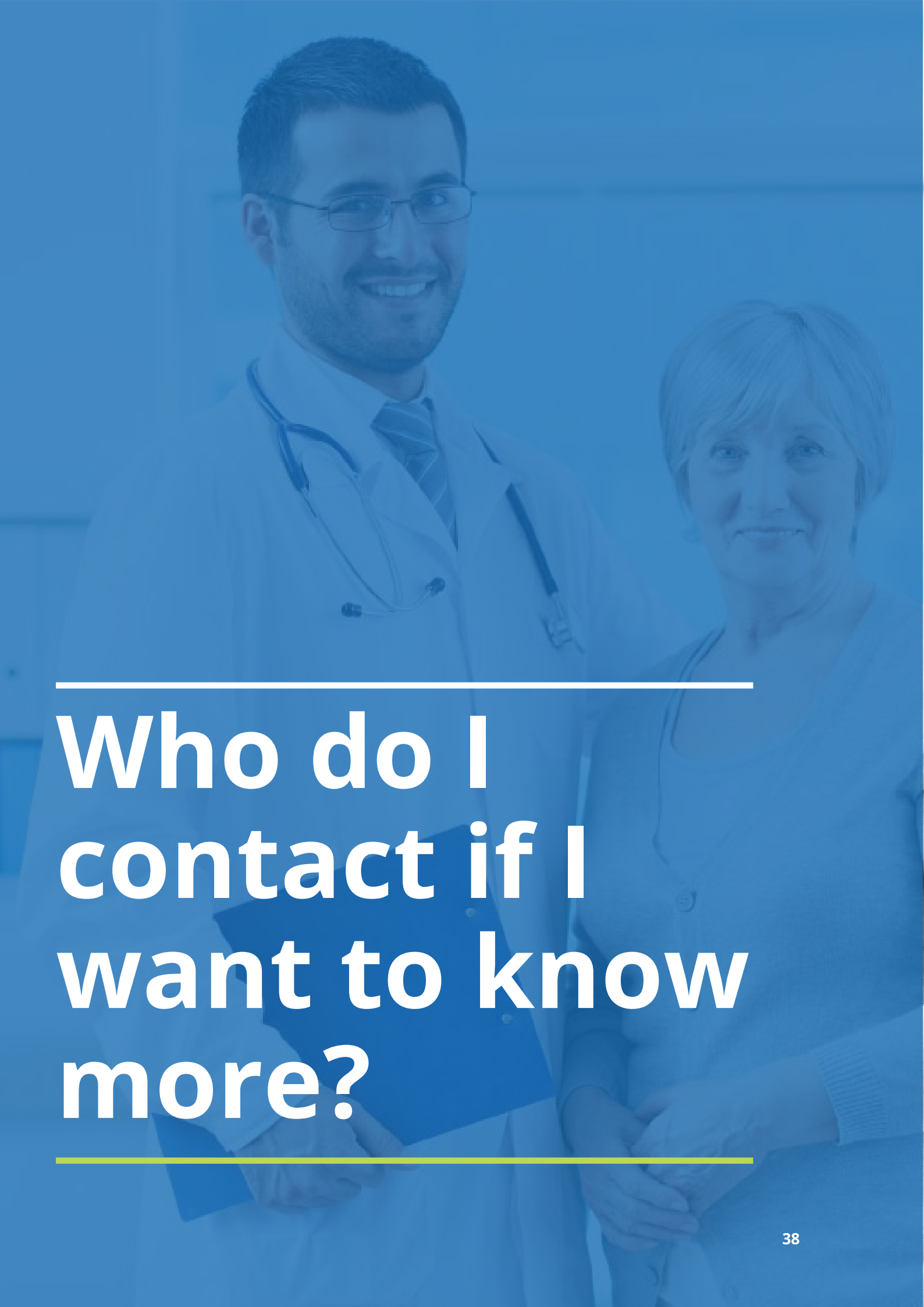
NOTES:

1. Total Benefit — This includes the medical rebates payable by Medicare and your Health Fund which together provide a contribution to the cost of the medical service. For a no gap product, it will equate to the practitioner's fee. For further information, patients should approach their Fund.
2. Patient Gap Payment — Where the Medicare and Health Insurance Fund rebates do no cover the entire cost of the medical service, the 'Patient Gap Payment' represents the part of the cost of the medical service which you, the patient, will pay yourself.

Parent/Guardian to Complete

The above estimated costs have been explained to my satisfaction. I understand that the above costs are an estimate and subject to variation. It is not a consent to, nor a request for a procedure.

Patient/Guardian's Signature **Date**



Who do I contact if I want to know more?

Support from AHSA

www.ahsa.com.au
(click on FOR DOCTORS)

Go to our website to download the following forms:

- Doctor Account form
- Account Summary form (Batch Header)
- Provider Details & Direct Credit Authority form (AGC Registration form)
- Additional Practice Locations form (to register new Medicare Provider Numbers with AGC)
- Estimate of Medical Fees form
- Change of Bank details Form

Also available on our website:

- AGC Billing Guide
- AGC Terms and Conditions
- AGC Participating Funds Contact List
- AGC Fee Schedules

1800 664 277 (freecall)

access@ahsa.com.au

- AGC registration queries
- Questions regarding AGC rules
- Further information about AGC in general

Support from funds

Individual Fund
(Refer to the Participating Funds Contact List)

- Claims Assessment
- Claim Enquiries
- Patient Eligibility
- Individual Fund Brochures
- Fund Administration Procedures

Australian Health Service Alliance