



Provider Registration Form Australian Defence Force Family Healthcare Program

Important Information

This registration form is to be used by Medical Practitioners to register to participate in the Australian Defence Force Family Healthcare Program.

Once your registration has been acknowledged your payments will be paid on a per-episode basis. Payments will be made direct to your nominated bank account.

Note: Your name, practice name and practice contact details will be published on the Department of Defence website for use by Australian Defence Force dependants. No banking or personal contact details will be released publicly. For further information, please see the privacy note on page 3.

Please supply details for each practice location that you wish to provide services from under this program. These practices must be located within the eligible area. If additional locations are required please attach a separate list.

Note: Electronic Funds Transfer payments can not be made to credit card, loan or mortgage accounts.

Assistance

For information relating to your registration or a payment made under the Program please call **1300 301 505**. For any other information on the Australian Defence Force Family Healthcare Program please call the Department of Defence on **02 6266 4467** (call charges may apply).

Lodgement

Send the completed and signed form to:

**Australian Defence Force Family Healthcare Program
Provider Registration Team
PO Box 9826
Hobart TAS 7001**

or fax to: **1300 093 177**

Tick where applicable

Provider's details

1 Dr Mr Mrs Miss Ms

Other

Family name

First given name

Other given name(s)

2 Date of birth

Provider's contact details

Note: If you practice at a number of locations within eligible areas, you can nominate where you would like your statements sent.

All statements to be sent to the address below (Provider's contact details).

Statements should be sent to individual practice locations where service is provided.

Please indicate your contact details below.

3 Postal address

 Postcode

4 Work phone number

Mobile phone number

Fax number

Email
 @

Practice locations

Note: The full eight digit Provider number is required.

Location 1

Note: The information provided for each Practice location must match the current information held by Medicare Australia for that particular location.

5 Provider number for the location

Practice name

Practice address

Postcode

Phone number

Would you like to use the financial details on file with Medicare Australia for the purposes of bulk billing for this provider number?

Yes

No please complete the details below.

6 Name of bank, building society or credit union

Branch where your account is held

Branch number (BSB)

Account number (this may not be your card number)

Account held in the name(s)

Location 2

7 Provider number for the location

Practice name

Practice address

Postcode

Phone number

Would you like to use the financial details on file with Medicare Australia for the purposes of bulk billing for this provider number?

Yes

No please complete the details below.

8 Name of bank, building society or credit union

Branch where your account is held

Branch number (BSB)

Account number (this may not be your card number)

Account held in the name(s)

Location 3

9 Provider number for the location

Practice name

Practice address

Postcode

Phone number

Would you like to use the financial details on file with Medicare Australia for the purposes of bulk billing for this provider number?

Yes

No please complete the details below.

10 Name of bank, building society or credit union

Branch where your account is held

Branch number (BSB)

Account number (this may not be your card number)

Account held in the name(s)

