CHANGE OF BANK DETAILS FORM

Use this form if you would like to **only update existing bank account details** to your current registration.

Please do not use this form to register Provider Numbers or update any other information.
We will assume all other existing billing details remain the same.

If other details have changed, please complete the Provider Registration forms instead.

Practitioner's Name: _____

Provider Number(s):_____

_____

Contact Person: _____ Ph: (____)_____

Contact Email: _____ Fax: (____)_____

DIRECT CREDIT DETAILS

Financial institution Name: _____

*Branch:*_____

Account Name: _____

BSB Number (Must be 6 digits)

Account number (maximum 9 digits)

I authorize the Australian Health Service Alliance Limited (ABN 75062860584) to keep a record of the above bank account details and to provide those details to all of the Access Gap Cover participating funds for the purpose of allowing those Funds to electronically transfer monies directly to the bank account detailed above.

I understand that if I provide another person's account details monies will be transferred into that account.

Signature: _____ *Date:* _____
(Practitioner's signature required)

Please return this form to Australian Health Service Alliance by either:

Email: access@ahsa.com.au or Free fax: 1800 670 898

Mail to: Australian Health Service Alliance, PO Box 425 KEW VIC 3101.

THIS FORM MAY BE PHOTOCOPIED