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.

Please tick one ☐ New Advice ☐ Amendment

ATTACHMENT 3

Part 1 : Practitioner Details

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

Practitioner Telephone

Practitioner Mobile

Practitioner E-mail

AHPRA number(s)

Medical Specialty(s)

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

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

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

ADDITIONAL PRACTICE LOCATION FORM

ATTACHMENT 3A

If you are adding additional provider numbers to an existing registration, please indicate the provider number this should be linked to. This form is not used to update any current information. Please use the Provider Details & Direct Credit Authority form to update your 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.

Details to be the same as registered Provider Number:

Practitioner's Name (in full)

AHPRA number(s)

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

Please return this form to Australian Health Service Alliance
Fax: 1800 670 898 or Email: access@ahsa.com.au