AUSTRALIAN HEALTH SERVICE ALLIANCE
Electronic Funds Transfer Form for Hospitals

Please return via email to: assistance@ahsa.com.au
Phone 1800 664 277 (option 2)
AHSA, Level 1A 35 Cotham Road, Kew, Victoria 3101

BANKING DETAILS

Business/Owner Name:

Hospital Name/s:

Hospital Provider No/s:

Bank:

Branch:

Account Name:

BSB Number:

Account Number:

REMITTANCE DETAILS

Contact Name/Area:

Position/Title/Area:

Contact Phone/Fax No

E-mail Address for Remittances:

Address for Remittances:

State/Postcode:

Signature:

Date: _____ / _____ / _____

I authorise the Australian Health Service Alliance Limited (ABN 75 062 860 584) to keep a record of the above account details and to provide those details to some or all of the health benefit funds which are members of AHSA for the purposes of allowing those funds to electronically transfer monies directly to the bank account details above. AHSA will not accept responsibility if the bank details provided by you are incorrect or subsequently changed without 14 days written notice using this form. I am authorised to provide this direct credit authorisation on behalf of the hospital/s specified above.