



# PROVIDER REGISTRATION FORM

To ensure our records are accurate for the payment of benefits, we would be pleased if you would complete the following provider details and return to us as soon as possible.

Provider Name: \_\_\_\_\_

Speciality: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Mobile Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Payments required in the following format:

1. **Cheque** - Made payable to: \_\_\_\_\_

**OR**

2. **Direct Credit:**

Name of financial institution: \_\_\_\_\_

BSB Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Name: \_\_\_\_\_

Contact person for account enquiries: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Additional provider numbers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Declaration: I hereby declare that the above information is true and correct.**

Signature of practitioner or authorised person: ..... Date:.....