



Application for a Medicare provider number and, or prescriber number for a medical practitioner

Purpose of this form

Complete this form if you are an eligible medical practitioner and would like to apply for an initial or subsequent Medicare provider number and, or a prescriber number.

To find out if you are eligible to register, claim or access Medicare services, please visit humanservices.gov.au/hpmedicarebenefits

Health Professionals Online Services (HPOS)

HPOS provides a secure and convenient online service for health professionals to streamline interactions with the department.

To access your record through HPOS you will need a PRODA account.

HPOS allows eligible health professionals to:

- apply for a **subsequent** location provider number
- update address and contact details
- update banking details
- update location organisation details
- close and re-open provider locations.

To register for a PRODA account and to find out more about HPOS, go to humanservices.gov.au/hpos

For more information

Go to humanservices.gov.au/healthprofessionals or call **132 150** Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

Note: Call charges may apply.

Filling in this form

- Please use black or blue pen.
- Print in BLOCK LETTERS.
- Mark boxes like this with a ✓ or X.
- Where you see a box like this Go to 5 skip to the question number shown. You do not need to answer the questions in between.

Note: An application will be returned if information is missing and/or not signed.

Have you considered applying through HPOS?

1 Is this application for an **initial** or **subsequent** Medicare provider number?

Initial

Subsequent Existing medicare provider number

Applicant's details

A provider number will be issued in the name in which you are registered with the Australian Health Practitioner Regulation Agency (AHPRA).

2 Dr Mr Mrs Miss Ms Other

Family name

First given name

Second given name

3 Your date of birth

4 Your gender

Male

Female

5 Languages spoken (other than English)



Required location

18 Are you applying for more than one location?

No

Yes



Print and attach a copy of pages 3 and 4, as required. Complete questions 19 to 31 for **each** additional location.

19 Location start date

Location end date

20 Which one of the following do you want to do at this location:

Tick ONE only

Refer and request only (e.g. hospital interns)

Refer, request and provide Medicare or Department of Veterans' Affairs rebateable services

Refer, request and assist at operations only

21 Are you in an approved Section 3GA Program?

No

Yes

Before your application can be finalised, the organisation authorised to approve your placement must complete and sign an approved placement form and send it to the Department of Human Services. For more information about approved Section 3GA Programs, go to health.gov.au

22 Practice information

Practice, hospital or health service name

Unit Suite Shop Floor number

Street number

Street name

Suburb

State Postcode

Practice phone number

Email

23 Will you be claiming Medicare benefits from this location?

No **Go to 32**

Yes

24 Your employment status at this location is:

Tick ONE only

Self Individual proprietor

Sole trader

Joint owner in a partnership

Employee Salaried

Contracting organisation

25 Business details relating to your employment at this location

Australian Business Number (ABN)

Australian Company Number (ACN) (If applicable)

Registered business name

Trading as

26 Business type:

Tick ONE only

Individual proprietor

Partnership

Unincorporated association

Company

State Government

Territory Government

Other public body

27 Premises type:

Tick ONE only

Hospital - public

Hospital - private

Practice - general practice

Practice - other private practice

Educational Institution

Residential care facility

Other community health care service

Home

Mobile

28 Does this practice use Medicare Online?

No

Yes Give details below

Practice Management Software Location ID

29 Does this practice use Medicare Easyclaim?

No

Yes Give details below

Name of the financial institution that supplied the EFTPOS device

30 Is this a government funded Aboriginal and Torres Strait Islander health service?

No

Yes

Bank account details

Please provide the bank account details for the recipient of Medicare benefit payments for location named at question 22.

All payments are made through Electronic Funds Transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT.

The nominated account for this location will be used for both Medicare and the Department of Veterans' Affairs benefit payments.

31 Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

Prescriber number

32 Do you want a prescriber number for prescribing Pharmaceutical Benefits Scheme medicines under the *National Health Act 1953*?

No

Yes

Checklist

33 If you obtained your base medical qualification from an overseas medical college, are subject to the Ten Year Moratorium and you require access to Medicare benefits you need to supply:

a copy of medical registration

personal pages of passport and current visa status

letter of support from employer as to why you require access to Medicare benefits and period required

Privacy notice

34 Your personal information is protected by law (including the *Privacy Act 1988*) and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department, or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

You can get more information about the way in which the department will manage your personal information, including our privacy policy, at humanservices.gov.au/privacy

Provider's declaration

35 I declare that:

- I am aware of my legal obligation to provide true and accurate information.
- I have read humanservices.gov.au/hpmedicarebenefits and understand my legislative requirements on the use of my Medicare provider number.

I acknowledge that:

- I must notify the department of any changes to my residency status as this change may impact my eligibility to access Medicare benefits.**

I understand that:

- giving false or misleading information is a serious offence and that the information I have provided on this form may be subject to scrutiny through the relevant compliance and audit arrangements.

Provider's full name

Provider's signature

Date

Returning your form

Check all required questions are answered and the form is signed and dated.

Your application will be returned to you if all relevant documentation is not supplied or is incomplete.

Send the completed form(s) to:

Department of Human Services

Provider Registration Section

GPO Box 9822

in your capital city

or

Fax:

NSW/ACT **02 9895 3439**

SA/TAS **08 8274 9307**

VIC/NT **03 9605 7984**

WA **08 9214 8201**

QLD **07 3004 5634**