GapCover APPLICATION FORM

medibank For Better Health

ahm Health Insurance

PART 1 PRACTITIONER DETAILS – for practice and member enquiries

*These details are mandatory

Provider name* ..... Provider number* .....

Area of Speciality* .....

Practice Name* .....

Practice Address* .....

Practice Telephone* ..... Practice Fax .....

Practice Email* .....

If more than one provider number/practice location please complete the second page of this form

PART 2 BILLING DETAILS – for billing and account enquiries

Billing Contact Name .....

Billing Name or Name of Registered Billing Agent .....

Postal Address .....

Billing Contact Telephone ..... Billing Contact Fax .....

Billing Contact Email .....

PART 3 BANKING/EFT DETAILS – for payment of benefits

Name of Financial Institution .....

Branch Address .....

Account Name .....

BSB Number* *(must be 6 digits)* ..... Account Number* .....

PART 4 AUTHORISATION

I declare that by completing this application form I am agreeing to the terms and conditions of the GapCover scheme. Terms and Conditions can be found in the GapCover Guide available at ***www.medibank.com.au/providers****.*

I authorise Medibank Private and ahm to keep a record of the above account details and to use for the purposes of allowing electronic funds transfer directly to the nominated account details for the payment of claims for eligible members. Neither Medibank Private nor ahm will accept responsibility for payment if the account details provided are incorrect. For any changes to account details a minimum 14 days written notice is required.

I understand that I will be made known as a GapCover participating provider unless I request otherwise by emailing ***gapcoveroptout@medibank.com.au****.*

Authorised Signature ..... Date .....

Please see 2nd page for additional locations

Please return the completed form by fax to: **03 8456 6250**

Medibank Private Limited ABN 47 080 890 259
Australian Health Management Group Pty Limited ABN 96 003 683 298

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ADDITIONAL PRACTICE LOCATIONS

Provider name ..... Provider number .....

Area of Speciality .....

Practice Name .....

Practice Address .....

Practice Telephone ..... Practice Fax .....

Provider name ..... Provider number .....

Area of Speciality .....

Practice Name .....

Practice Address .....

Practice Telephone ..... Practice Fax .....

Provider name ..... Provider number .....

Area of Speciality .....

Practice Name .....

Practice Address .....

Practice Telephone ..... Practice Fax .....

Provider name ..... Provider number .....

Area of Speciality .....

Practice Name .....

Practice Address .....

Practice Telephone ..... Practice Fax .....

Provider name ..... Provider number .....

Area of Speciality .....

Practice Name .....

Practice Address .....

Practice Telephone ..... Practice Fax .....