medibank
For Better Health

Provider EFT Form

Completing this form:

Step 1: Please check that you can fill in this form digitally. You may need to download Adobe Acrobat Reader DC before you start.
Step 2: Download/save the form first onto your computer. Do not complete the form before downloading it.
Step 3: Complete **digitally**[1] by typing in all mandatory fields denoted by an asterisk [*]. Please note that only digitally completed forms will be accepted.
Step 4: Click the **Verify** button at the bottom of the last page to verify all mandatory fields have been completed. If you are prompted to fill in missing mandatory fields, please do so and re-verify the form. Please note that only forms with all mandatory fields filled in will be accepted for reviewing and processing.
Step 5: Once the form is verified, please save the form by clicking '**File**' at the top left of your PDF reader and select either '**Save**' or '**Save As…**' prior to emailing the form. Please note that **printing** or **scanning** of the verified form will not be accepted as a valid submission.

[1] **Handwritten forms will no longer be accepted via email.**

Additional information for Mac users:

In OS X, Apple's 'Preview' is the default application for opening a number of file types, including PDF's.
Preview will NOT allow you to complete this PDF form with editable content.
Follow these instructions to set Adobe Acrobat Reader as the default application for opening PDF files.
Step 1: Single click a GapCover PDF file already saved on the local computer while holding the Control key. Then select *GET INFO* from the menu you've opened.
Step 2: Click the drop down menu for *OPEN WITH.*
Step 3: Select ADOBE ACROBAT READER from the menu.
Step 4: Click on the CHANGE ALL button to keep the changes.

Submitting completed form:

- Via email : **Medical_AncillaryProviders@medibank.com.au**

Multiple locations to be specified:

Please complete section 4 of this form and if you need to update more locations than specified in the section, please enquire with us via the email address above.

Please select your request type*

Section 1: Provider Details

Title

Date of Birth

Provider First Name*

Provider Middle Name

Provider Last Name*

AHPRA Registration Number

Check AHPRA Registration Number here.

Professional Contact Details

Email*

Area Code*

Phone Number*

In providing us with your professional contact email address, you agree to receiving general correspondence from Medibank Private Limited related to company processes and the Private Health Insurance sector. To read our privacy policy and find out more about how we handle your personal information visit www.medibank.com.au.

Section 2: EFT and Billing Details

EFT Details

BSB Number* -

Account Number*

Account Name*

Billing Details

First Name

Last Name

Address Line 1*

Address Line 2

Suburb*

State*

Post Code*

Email*

Area Code*

Phone Number*

Please note: EFT and Billing Details will apply to the Medicare registered provider numbers specified under Section 4.

In providing us with your billing email address, you agree to Medibank Private Limited sending remittance advices and benefit statements by email. To read our privacy policy and find out more about how we handle your personal information visit www.medibank.com.au.

Section 3: Authorisation

I declare that, by completing this application form, I authorise Medibank Private Limited to keep a record of the above account details and to use them for the purpose of allowing electronic funds transfers directly to the nominated account to effect the payment of claims for eligible members. Medibank Private Limited will not accept any responsibility for payment if the account details provided are incorrect. For any changes to account details, a minimum of 14 days' written notice is required.

Name of Authorised Person*

Position of Authorised Person*

By checking this box, I ***confirm that I have the authority*** to submit this form. *

Date*

Please refer to Section 4 for Medicare Registered Location Addresses.

Section 4: Medicare Registered Location Addresses

Note:

Complete required details for all Medicare Registered locations in the table below. The details supplied here must apply to the provider listed in Section 1.

Provider Number*	Location Post Code*	Phone Area Code	Phone Number

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Click here before you save the completed form