

## GapCover/No Gap Program Application and Change of Details Form

### (For Provider Use Only)

#### 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**<sup>1</sup> 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.

<sup>1</sup> 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/No Gap Program 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 : [GapCoverForms@medibank.com.au](mailto:GapCoverForms@medibank.com.au)

Medibank does not retain a copy of this form once it has been processed. You may wish to make a copy for your own records before submitting it.

#### 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 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](#).  
ABN

#### 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 and ahm Health Insurance 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](http://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 addresses specified under Section 4.*

*In providing us with your billing email address, you agree to Medibank Private Limited and ahm Health Insurance 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](http://www.medibank.com.au).*

### Section 3: Authorisation

*I authorise Medibank Private Limited and ahm Health Insurance 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. Neither Medibank Private Limited nor ahm Health Insurance accepts 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.*

#### **For Providers who wish to submit claims using Medibank's GapCover Scheme**

*I declare that, by completing the application form, I am agreeing to the terms and conditions of the GapCover scheme which can be found [here](#). I understand that the terms and conditions of the GapCover scheme do not apply in relation to claims submitted under Medibank's No Gap program*

I **do not consent** to be published as a GapCover Provider.

*Unless you check the above box, we assume you consent to be published as a GapCover Provider for Medibank Private Limited and ahm, which will include all details in Section 1 and 4 of this form, with the exception of Provider Number and AHPRA registration number.*

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 GapCover/No Gap Program Participating Locations.*

## Section 4: GapCover/No Gap Program Participating Locations

**Note:**  
Complete required details for all GapCover/No Gap Program participating 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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Provider Number*	Location Post Code*	Phone Area Code*	Phone Number*
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*[Click here before you save the completed form](#)*