

Medibank OSHC Direct Billing Change in Clinic & Provider Information Form – Schedule 2



This form must be completed and provided to Medibank within 5 Business Days of a change occurring.

I would like to update the Direct Billing Clinic Contact Details in the Service Agreement Form as follows:

Business Name & ABN: <small>(Must be completed)</small>			
Direct Billing Clinic Name:			
Address:			
Suburb:		State:	Postcode:
New General Practice Accreditation: <small>(e.g. AGPAL or GPA)</small>			
Other: <small>(e.g. authorised person / contact details)</small>			

Gap Payment

I would like to advise a change in the Gap charged by the Direct Billing Clinic for Medibank Policy Holders.

Previous Gap charged: \$	New Gap charged: \$
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Provider Information

I would like to:

- add the below Provider; or
- remove the below Provider,
- Update the Medical Clinics/Providers banking information

from the Direct Billing Clinic's Medibank OSHC Direct Billing Service Agreement

First Name:		Surname:	
Email:		Phone:	
Provider Number:			
Benefits Paid To:	<input type="checkbox"/> Medical Clinic	<input type="checkbox"/> Provider	
Account name:			
BSB Number: <small>(must be 6 digits)</small>		Account Number:	

Additional practicing clinic locations

The Provider is practicing in multiple Direct Billing Clinic locations

Provider Name:	
Additional Direct Billing Clinic Name:	
Address:	
Provider Number:	
Primary Clinic Contact:	

Authorisation

I acknowledge that this constitutes an amendment of the OSHC Direct Billing Service Agreement in accordance with clauses 4.2 and 15.1. I authorise Medibank to keep a record of the above account details and to use it for the purposes of allowing electronic funds transfer directly to the nominated account details for the payment of Medibank OSHC claims for eligible members. Medibank will not be held responsible for payment if the account details provided are incorrect. For any changes to account details a minimum 14 days written notice is required.

Authorised Person's Signature:	Date:
Provider Signature:	Date:

Please return completed form to: oshc.enquiries@medibank.com.au

