Medibank OSHC Direct Billing User Access Form

This form must be completed by an authorised person.

Clinic Information			
Business Name and ABN: (Must be Completed)			
Direct Billing Clinic Name:			
Address:			
Suburb:		**State:**	**Postcode:**
Authorised Person:			

Users Contact Details			
I would like to: ☐ Add the following User Access Details ☐ Remove the following User Access Details		**I would like to:** ☐ Add the following User Access Details ☐ Remove the following User Access Details	
Title:	Mr ☐ Mrs ☐ Ms☐ Miss ☐ Dr ☐	**Title:**	Mr ☐ Mrs ☐ Ms☐ Miss ☐ Dr ☐
First Name:		**First Name:**	
Last Name:		**Last Name:**	
Email Address: (Must be unique)		**Email Address:** (Must be unique)	

Clinic Authorisation	
Authorised Person's Signature:	**Date:**
Please return completed form to: oshc.enquiries@medibank.com.au	