



# PROVIDER REGISTRATION FORM

## 1. DETAILS:

Title:	<input type="text"/>	Surname:	<input type="text"/>
First Name/Other Name(s):	<input type="text"/>		
Address:	<input type="text"/>		
<input type="text"/>			
Mobile:	<input type="text"/>	Fax:	<input type="text"/>
Phone:	<input type="text"/>	Email:	<input type="text"/>

## 2. PROVIDER NUMBERS: Please list all provider numbers you wish us to bill under. Please tick the

boxes below if the provider number listed are already registered with Health Funds for billing purpose.

Provider Number	Practice Address	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

### 2.1 Reconciliation of your Claims:

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Please tick this box if you authorise 'Doctor Claim' to change your postal address with Medicare and Health Funds. This will ensure that the postal address for 'Doctor Claim' is listed as your mailing address for Medicare and Health Fund remittance advices only.

Please note payments will always be made in favour of the provider not 'Doctor Claim'.

## 3. BANKING DETAILS:

Bank Name:	<input type="text"/>
Account Name:	<input type="text"/>
BSB Number:	<input type="text"/>
Account Number:	<input type="text"/>

## 4. LETTER HEAD DETAILS: (Will appear on your invoices and letters to patients)

Name:	<input type="text"/>
ABN:	<input type="text"/>
Company Name:	<input type="text"/>
Qualifications:	<input type="text"/>
Specialty/ies:	<input type="text"/>

## 5. PROVIDER SIGNATURE: I hereby request to be registered as a client of 'Doctor Claim'

Name:	<input type="text"/>
Signature:	<input type="text"/>
Date:	<input type="text"/>

Please Return your completed registration form to 'Doctor Claim':

By Mail: PO Box 6267 Kincumber NSW 2251      OR      By Fax: 1300 760 803      OR      By email: [accounts@doctorclaim.com.au](mailto:accounts@doctorclaim.com.au)