



# REGISTRATION FORM

## DETAILS

Title  Surname

First Name  Gender M  F

Address

Mobile  Fax

AHPRA Reg  Email

ABN  PRODA Number  Specialty/ies

Qualifications  Date of Birth

## PROVIDER DETAILS

Please tick the box below if the provider number listed is already registered for billing with the health funds.

Provider Number	Location Address	Tick Box
<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"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

## BANKING DETAILS (All Health Fund payments will be deposited directly into your bank account)

Bank Name  Branch

Account Name

BSB  Account Number

Do you need us to complete your Health Fund Registration?  Yes  No How did you hear about us?

If you are already registered what is your BUPA Practice ID number

Do you currently have a No Gap Agreement with any Health funds?  Yes  No  Not Sure

## SIGNATURE (I hereby request to be registered as client of 'Australian Medical Billing Service')

Name

Signature

Please return your completed registration form to 'Australian Medical Billing Service'

Email: info@ausmbs.com.au

Please contact us on 1300 002 839 if you require further information.