Australian Government
Department of Human Services

medicare

Application for a Medicare provider number and, or prescriber number for a medical practitioner

Purpose of this form

Complete this form if you are an eligible medical practitioner and would like to apply for an initial or subsequent Medicare provider number and, or a prescriber number.

To find out if you are eligible to register, claim or access Medicare services, please visit **humanservices.gov.au/hpmedicarebenefits**

Health Professionals Online Services (HPOS)

HPOS provides a secure and convenient online service for health professionals to streamline interactions with the department.

To access your record through HPOS you will need a PRODA account.

HPOS allows eligible health professionals to:

- apply for a **subsequent** location provider number
- update address and contact details
- update banking details
- update location organisation details
- close and re-open provider locations.

To register for a PRODA account and to find out more about HPOS, go to **humanservices.gov.au/hpos**

For more information

Go to **humanservices.gov.au/healthprofessionals** or call **132 150** Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

Note: Call charges may apply.

Filling in this form

- **Please use black or blue pen.**
- Print in BLOCK LETTERS.
- Mark boxes like this ☐ with a ✓ or ✗.
- Where you see a box like this ☐▶ ***Go to 5*** skip to the question number shown. You do not need to answer the questions in between.

Note: An application will be returned if information is missing and/or not signed.

STOP Have you considered applying through HPOS?

1 Is this application for an **initial** or **subsequent** Medicare provider number?

Initial ☐

Subsequent ☐▶ Existing medicare provider number

Applicant's details

A provider number will be issued in the name in which you are registered with the Australian Health Practitioner Regulation Agency (AHPRA).

2 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Second given name

3 Your date of birth

/ /

4 Your gender

Male ☐

Female ☐

5 Languages spoken (other than English)

MCA0HW019 1809

Residency status

You **must** immediately notify the Department of Human Services of **any change** in your residency status.

6 Were you born in Australia?

No ☐

Yes ☐ ***Go to 11***

7 Are you currently a temporary resident?

No ☐

Yes ☐ ***Go to 9***

8 What date did you become a permanent resident or Australian citizen?

/ /

9 Are you a New Zealand citizen or New Zealand permanent resident?

No ☐

Yes ☐

Qualifications

10 Did you obtain your primary medical qualification in an accredited medical school in Australia or New Zealand?

No ☐

Yes ☐ Please supply evidence of your residency status at your date of enrolment.

11 Primary medical qualification

Country obtained

Medical school

Year obtained

12 Have you signed a Scholarship Scheme agreement with the Department of Health?

No ☐

Yes ☐ BMP ☐ **or** MRBS ☐

Personal contact details

13 Postal address

Postcode

14 Business phone number

( )

Mobile number

Email

@

Registration details

15 AHPRA Registration number

You **cannot** be allocated a provider number unless you are registered with the Medical Board of Australia.

Attach a copy of your current medical registration certificate if applying for an initial provider number.

16 Were you registered with an Australian Medical Board **prior to 1 January 1997**?

No ☐

Yes ☐ Provide a copy of the medical board registration from the date of first registration.

Recognition

If recognition is required for access to Medicare as a general practitioner, specialist or consultant physician, you must also complete an ***Application for recognition as a Specialist or Consultant Physician*** form (**HW077**) or ***Application for certification of eligibility for Vocational Registration of General Practitioners*** form (**HW060**) available from **humanservices.gov.au/organisations/health-professionals/forms/by-code**

17 Have you applied for recognition as a:

Specialist or consultant physician ☐

General practitioner ☐

This information will be used if we need to apply to the Department of Health for a section 19AB exemption on your behalf.

Required location

18 Are you applying for more than one location?

No ☐

Yes ☐ Print and attach a copy of pages 3 and 4, as required. Complete questions 19 to 31 for **each** additional location.

19 Location start date / /

Location end date / /

20 Which one of the following do you want to do at this location:

Tick ONE only

Refer and request only (e.g. hospital interns) ☐

Refer, request and provide Medicare or Department of Veterans' Affairs rebateable services ☐

Refer, request and assist at operations only ☐

21 Are you in an approved Section 3GA Program?

No ☐

Yes ☐

Before your application can be finalised, the organisation authorised to approve your placement must complete and sign an approved placement form and send it to the Department of Human Services. For more information about approved Section 3GA Programs, go to **health.gov.au**

22 Practice information

Practice, hospital or health service name

Unit Suite Shop Floor number

Street number

Street name

Suburb

State Postcode

Practice phone number

( )

Email

@

23 Will you be claiming Medicare benefits from this location?

No ☐ ***Go to 32***

Yes ☐

24 Your employment status at this location is:

Tick ONE only

Self
- Individual proprietor ☐
- Sole trader ☐
- Joint owner in a partnership ☐

Employee
- Salaried ☐
- Contracting organisation ☐

25 Business details relating to your employment at this location

Australian Business Number (ABN) – – –

Australian Company Number (ACN) (If applicable) – –

Registered business name

Trading as

26 Business type:

Tick ONE only

- Individual proprietor ☐
- Partnership ☐
- Unincorporated association ☐
- Company ☐
- State Government ☐
- Territory Government ☐
- Other public body ☐

27 Premises type:

Tick ONE only

- Hospital - public ☐
- Hospital - private ☐
- Practice - general practice ☐
- Practice - other private practice ☐
- Educational Institution ☐
- Residential care facility ☐
- Other community health care service ☐
- Home ☐
- Mobile ☐

28 Does this practice use Medicare Online?

No ☐

Yes ☐ Give details below

Practice Management Software Location ID

29 Does this practice use Medicare Easyclaim?

No ☐

Yes ☐ Give details below

Name of the financial institution that supplied the EFTPOS device

30 Is this a government funded Aboriginal and Torres Strait Islander health service?

No ☐

Yes ☐

Bank account details

Please provide the bank account details for the recipient of Medicare benefit payments for location named at question 22.

All payments are made through Electronic Funds Transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT.

The nominated account for this location will be used for both Medicare and the Department of Veterans' Affairs benefit payments.

31 Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

Prescriber number

32 Do you want a prescriber number for prescribing Pharmaceutical Benefits Scheme medicines under the *National Health Act 1953*?

No ☐

Yes ☐

Checklist

33 If you obtained your base medical qualification from an overseas medical college, are subject to the Ten Year Moratorium and you require access to Medicare benefits you need to supply:

a copy of medical registration ☐

personal pages of passport and current visa status ☐

letter of support from employer as to why you require access to Medicare benefits and period required ☐

Privacy notice

34 Your personal information is protected by law (including the *Privacy Act 1988*) and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department, or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

You can get more information about the way in which the department will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy**

Provider's declaration

35 **I declare that**:

- I am aware of my legal obligation to provide true and accurate information.
- I have read **humanservices.gov.au/hpmedicarebenefits** and understand my legislative requirements on the use of my Medicare provider number.

I acknowledge that:

- **I must notify the department of any changes to my residency status as this change may impact my eligibility to access Medicare benefits.**

I understand that:

- giving false or misleading information is a serious offence and that the information I have provided on this form may be subject to scrutiny through the relevant compliance and audit arrangements.

Provider's full name

Provider's signature

On completion, print and sign by hand.

Date / /

Reset form Print form

Returning your form

Check all required questions are answered and the form is signed and dated.

Your application will be returned to you if all relevant documentation is not supplied or is incomplete.

Send the completed form(s) to:

Department of Human Services
Provider Registration Section
GPO Box 9822
in your capital city

or

Fax:

NSW/ACT	**02 9895 3439**	SA/TAS	**08 8274 9307**
VIC/NT	**03 9605 7984**	WA	**08 9214 8201**
QLD	**07 3004 5634**		