Electronic Funds Transfer Payment Request



		Busines	ss Pa	artner Nui	mber:							
Name:					•	•	,	'				
Previous surname: (if applicable) ABN (Business) or												
Date of Birth (Patient):												
Address:									_			
Suburb:							Pos	stcode:				
PO Box:		Suburb:						stcode:				
Telephone (home):	Telephone (mobile):											
Bank details												
BSB Number:					-							
Bank Account Number:			•									
Bank Account Holder's Name:						ı	1					
Email Address for payment advice:												
authorise all future paym changes to the above ban Businesses: For your pro Company letterhead with	nk details. otection, ple	ease supp	ort y	our bank o	details by	supp	lying	g one c	of the	e foll	lowin	g.
Account Holder:				Witnessed by:								
(Signature)						(:	Sign	nature)				
Name:				Name: _								
Date:				Date:								

Please forward this completed request to your HHS/DoH contact:

Personal information collected by the Department of Health (DoH) is handled in accordance with the *Information Privacy Act 2009*. The DoH is collecting your personal information to process claims for payment. All personal information will be securely stored and only accessible by appropriately authorised officers of the department. Your personal information will not be disclosed to other third parties without consent unless the disclosure is authorised or required by or under law. For information about how DoH protects your personal information, or to learn about your right to access your own personal information, please see our website at www.health.gld.gov.au.