

ACCESS BILLING REGISTRATION FORM

CONTACT DETAILS

Name: _____

Qualifications (e.g. FRACP): _____

Preferred Postal Address: _____

Phone Number(s): Home: _____

Office: _____

Fax Number(s): Home: _____

Office: _____

Mobile: _____ Pager: _____

Email: _____

ABN: _____

PRACTICE DETAILS

Specialty: _____

Sessions Per Week (Consulting/Operating): _____

Provider Locations/Provider Numbers (continue overleaf if required):

1. _____

2. _____

3. _____

BANKING DETAILS

Name of Account: _____

Bank & Branch Where Account Held: _____

BSB/Account Number: _____