

Thank you for choosing HICAPS, Australia's leading health claiming service. The following information is necessary for us to arrange pre-completed contracts for the HICAPS/EFTPOS service.

When completed – Fax to us on **1300 737 035** or Mail to Locked Bag, 20027, Melbourne Vic 8060.

Select and tick box relevant to your request.

New application – New terminal
Please complete sections: **A, B & C only**

New application – **Existing** terminal
Please complete **all** sections

A Provider Details

Profession/Speciality _____

Given name(s) _____

Registered company name (If applicable) _____

ACN/ABN _____ Business Name Reg. number _____

Site address _____ State _____ Postcode _____

Phone _____ Fax _____ E-mail _____

Title Dr Mr Mrs Miss Ms Other _____

Surname _____

Registered trading name (If applicable) _____

Name all Directors/Partners _____

Mailing address _____ State _____ Postcode _____

Please include a copy of a Medicare Australia or Medibank Private letter for all providers listed on this application when you return your completed HICAPS contracts. Chiropractors, Dentists, Dietitians, Occupational Therapists, Optometrists, Osteopaths, Podiatrists, Psychologists, Clinical Psychologists, Physiotherapists, Speech Pathologists, Dental Prosthetists – please provide your **Medicare** Australia provider number. Optical Dispensers, Naturopaths, Acupuncturists, Remedial Massage Therapists – please provide your **Medibank** Private provider number. Myotherapists – please provide your **Medibank** Private Remedial Massage Therapy and IRMA registration letter. If you do not hold either a **Medicare** Australia or **Medibank** Private provider number and would like to transact via HICAPS as you are registered with other Health Funds for claiming purposes, please call HICAPS on 1800 80 57 80 for further information.

B Additional Provider Details

Given name	Surname	Profession/Speciality	Provider number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C Bank Details

Bank name _____

(Debits) Account name (Please attach a copy of a bank deposit slip) _____ BSB _____ A/C number _____

(Credits) Account name (Please attach a copy of a bank deposit slip) _____ BSB _____ A/C number _____

D Multi-Merchant Facilities (MMF) – Please complete this section to add this facility to an existing HICAPS terminal.

Terminal owner/s Declaration

I/we hereby authorise this facility to be added to my/our terminal number S and the upgrade of my terminal to a MMF if necessary.

Signature - terminal owner/s _____ Date ____/____/____

Please Note: All signatories to the original HICAPS Equipment Agreement are required to sign.

For further information please contact your HICAPS sales representative on 1800 80 57 80