

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 725 726** or Mail to GPO Box 84A, Melbourne Vic 3001.

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) \_\_\_\_\_ Surname \_\_\_\_\_

Registered company name (If applicable) \_\_\_\_\_ Registered trading name (If applicable) \_\_\_\_\_

ACN/ABN \_\_\_\_\_ Business Name Reg. number \_\_\_\_\_

Name all Directors/Partners \_\_\_\_\_

Site address \_\_\_\_\_ Mailing address \_\_\_\_\_

State Postcode State Postcode

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

**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**