New Facility – Practice Details

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.

Help desk Reference (HICAPS Use Only)

When completed: Fax us on **1300 725 726** or Mail to: HICAPS Pty Ltd, Ground Floor, 151 Rathdowne St, Carlton, VIC 3053

Please complete the following in **BLOCK PRINT**

Please amend the following details: (Tick box relevant to your request)

☐ New HICAPS Terminal (Please complete sections; **A, B & C Only**)

☐ New EFTPOS Facility on Existing HICAPS Terminal (Please complete **all** sections)

A New EFTPOS Facility Owner Details

Profession/Speciality

Title ☐ Mr ☐ Dr ☐ Miss ☐ Mrs ☐ Ms ☐ Other _____

Given name(s)

Surname

Registered company name (if applicable)

Registered trading name (if applicable)

ACN/ABN

Name all Directors/Partners

Site Address

State Postcode

Mailing Address

State Postcode

Site Phone Number: Install Contact Number: Fax Number:

B Provider Details (if applicable)

Given name(s)	Surname	Profession/Speciality	Provider Number

Important Note: All requests to add 'New Providers' must be accompanied by a copy of the letter issuing the Provider number. Chiropractors, Physiotherapists, Dentists (inc Dental Prosthetists), Dieticians, Occupational Therapists, Optometrists, Osteopaths, Podiatrists, Psychologists and Speech Pathologists – Please provide your **Medicare Australia letter**.

Acupuncturists, Remedial Massage Therapists, Naturopaths & Myotherapists – Please provide your **Medibank Private** letter and **Professional Association Membership/Registration**. Optical Dispensers – Please provide your **Medibank Private** letter.

C Bank Details (including deposit slip or bank statement header to validate account details)

Account Name (Debits)	Bank	BSB	Account Number
		–	
Account Name (Credits)	**Bank**	**BSB**	**Account Number**
		–	

D Existing Terminal Owner Authority to Add New EFTPOS Facility

I/we hereby authorise this facility to be added to my/our existing Multi-Merchant Facility/terminal (S I I I I A)

Signature	Name	Date
		/ /
Signature	Name	Date
		/ /