GapCover Application and Change of Details Form

(For Provider Use Only)

Completing this form:

Step 1: Please check that you can fill in this form digitally. You may need to download Adobe Acrobat Reader DC before you start.
Step 2: Download/save the form first onto your computer. Do not complete the form before downloading it.
Step 3: Complete **digitally**[1] by typing in all mandatory fields denoted by an asterisk [*]. Please note that only digitally completed forms will be accepted.
Step 4: Click the **Verify** button at the bottom of the last page to verify all mandatory fields have been completed. If you are prompted to fill in missing mandatory fields, please do so and re-verify the form. Please note that only forms with all mandatory fields filled in will be accepted for reviewing and processing.
Step 5: Once the form is verified, please save the form by clicking '**File**' at the top left of your PDF reader and select either '**Save**' or '**Save As…**' prior to emailing the form. Please note that **printing** or **scanning** of the verified form will not be accepted as a valid submission.

[1] **Handwritten forms will no longer be accepted via email.**

Submitting completed form:

- Via email : **GapCoverForms@medibank.com.au**

Multiple locations to be specified:

Please complete section 4 of this form and if you need to update more locations than specified in the section, please enquire us via the email address above.

Please select your request type*

Section 1: Provider Details

Title
Date of Birth
Provider First Name*
Provider Middle Name
Provider Last Name*
AHPRA Registration Number*
Check AHPRA Registration Number here.
ABN

Professional Contact Details
Email*
Area Code*
Phone Number*

In providing us with your professional contact email address, you agree to receiving general correspondence from Medibank Private Limited and ahm Health Insurance related to company processes and the Private Health Insurance sector. To read our privacy policy and find out more about how we handle your personal information visit www.medibank.com.au.

Section 2: EFT and Billing Details

EFT Details
BSB Number* -
Account Number*
Account Name*

Billing Details
First Name
Last Name
Address Line 1*
Address Line 2
Suburb*
State*
Post Code*
Email*
Area Code*
Phone Number*

Please note: EFT and Billing Details will apply to the Medicare registered provider numbers specified under Section 4.
In providing us with your billing email address, you agree to Medibank Private Limited and ahm Health Insurance sending remittance advices and benefit statements by email. To read our privacy policy and find out more about how we handle your personal information visit www.medibank.com.au.

Section 3: Authorisation

I declare that, by completing this application form, I am agreeing to the terms and conditions of the GapCover scheme which can be found here. I authorise Medibank Private Limited and ahm Health Insurance to keep a record of the above account details and to use them for the purpose of allowing electronic funds transfers directly to the nominated account to effect the payment of claims for eligible members. Neither Medibank Private Limited nor ahm Health Insurance accepts responsibility for payment if the account details provided are incorrect. For any changes to account details, a minimum of 14 days' written notice is required.

☐ I ***do not consent*** to be published as a GapCover Provider.

Unless you check the above box, we assume you consent to be published as a GapCover Provider for Medibank Private Limited and ahm Health Insurance, which will include your title and name in Section 1, Medicare registered addresses of the provider numbers and your phone numbers specified in Section 4 of this form.

Name of Authorised Person*
Position of Authorised Person*
☐ By checking this box, I ***confirm that I have the authority*** to submit this form. *

Date*

Please refer to Section 4 for GapCover Participating Locations.

Section 4: GapCover Participating Locations

Note:

Complete required details for all GapCover participating locations in the table below. The details supplied here must apply to the provider listed in Section 1.

Provider Number*	Location Post Code*	Phone Area Code*	Phone Number*	Provider Number*	Location Post Code*	Phone Area Code*	Phone Number*

Click here before you save the completed form Verify