



# Authority to authorise pharmacist(s) to sign claim forms on behalf of section 91 permission holder

## Purpose of this form

As permission holder under section 91 of the *National Health Act 1953*, you must complete this form to authorise a pharmacist(s) to sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on your behalf.

## For more information

Go to [www.health.gov.au/pbsapprovedsuppliers](http://www.health.gov.au/pbsapprovedsuppliers).  
For assistance completing this form, email [pbsapprovedsuppliers@health.gov.au](mailto:pbsapprovedsuppliers@health.gov.au) and a departmental officer will contact you, or call **1800 316 389** (call charges may apply).

## Returning your form

Check that all required questions are answered and the form is signed and dated.

This authority form must be lodged through the PBS Approved Suppliers Portal [PBSApprovedSuppliers.health.gov.au](http://PBSApprovedSuppliers.health.gov.au).

For further information on how to lodge your form visit [www.health.gov.au/pbsapprovedsuppliers](http://www.health.gov.au/pbsapprovedsuppliers). Please do **not** email your form as emailed forms may not be processed.

## Privacy and your personal information

Personal information is protected by law, including the *Privacy Act 1988*.

Personal information is being collected in this form by the Australian Government Department of Health (the Department) for the purposes of assessing your authorisation of a pharmacist(s) to sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on your behalf.

If you do not provide this information, the Department will not be able to assess your authorisation.

You can get more information about the way in which the Department will manage personal information, including our privacy policy, at [www.health.gov.au/pbsapprovedsuppliers/forms-privacy](http://www.health.gov.au/pbsapprovedsuppliers/forms-privacy).

## Permission holder

### 1 Name of permission holder

Dr  Mr  Ms  Other

Family name

First given name

## Approved premises

### 2 PBS approval number

### 3 Address of pharmacy premises

  


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 Postcode

## Authorised pharmacist(s)

### 4 Give details of all authorised pharmacists

#### Authorised pharmacist 1

Dr  Mr  Ms  Other

Family name

First given name

Registration number

Signature

