Australian Government

Department of Health

Notification of bank account details for a hospital authority

Purpose of this form

If you are a hospital authority approved under section 94 or section 100 of the *National Health Act 1953*, complete this form to update or provide your banking details to the Australian Government Department of Health (the Department) for payments made through claiming for the Pharmaceutical Benefits Scheme (PBS).

You will need to allow **10 working days** for the change to take effect.

Payments for PBS claims can only be paid to the approved hospital authority's bank account.

For more information

Go to **www.health.gov.au/pbsapprovedsuppliers**.
For assistance completing this form, email **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 notification form must be lodged through the PBS Approved Suppliers Portal **PBSApprovedSuppliers.health.gov.au**.

For further information on how to lodge your form visit **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 Department for the purposes of processing your notification of an approved hospital authority's new bank account details or changes to existing bank account details for the purposes of claiming for the Pharmaceutical Benefits Scheme.

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

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**.

Hospital authority details

1 Hospital authority name

2 PBS approval number

3 Hospital name

4 Hospital address

Postcode

5 Hospital switchboard phone number

Contact person's details

6 Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

7 Position held

8 Daytime phone number

Email

Hospital authority bank account details

9 I would like to:

Tick ONE only

Register new bank account details ☐ ***Go to 11***

Change bank account details ☐ *Go to next question*

10 If notifying the Department of a change to bank account details, record the old bank account details below.

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

11 Register new bank account details below.

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

All payments are made through Electronic Funds Transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT deposits.

Declaration

12 **I authorise**:

- payments to be made into the approved hospital authority's bank account.

I declare that:

- I am authorised to provide these details on behalf of the hospital authority.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Name

Signature

Date

/ /

Position held

Contact phone number

Clear form Print form