Instructions

Australian Government
Services Australia

medicare

Application to register or amend a diagnostic imaging or radiation oncology practice (HW061)

When to use this form

Use this form to register, amend, renew, relocate or close a diagnostic imaging or radiation oncology practice. A completed application form is required for each premises.

To print additional copies of this form, go to **servicesaustralia.gov.au/lspn**

Your Location Specific Practice Number

- A Location Specific Practice Number (LSPN) will be allocated to your practice after a completed application has been submitted and your application is approved.
- The practice will be registered from the date we receive a complete and correct application or, if requested, a specific date in the future.
- We will confirm your registration in writing and advise you of your practices' LSPN.
- Diagnostic imaging practices can apply for accreditation after an LSPN is allocated.
- An LSPN is location specific. If a registered practice is relocating, you can use this form to tell us before relocating. A new LSPN will be allocated to your practice for the new location.

Important information

Registered practices and their allocated LSPN are published on the LSPN register. To access the LSPN register, go to **servicesaustralia.gov.au/lspn**

Maintaining your registration

In order to maintain registration, your practice must advise us in writing **within 28 days** of any changes to the:

- proprietor details (including the proprietor's address for bases for mobile equipment)
- the Australian Company Number (ACN) if the proprietor is a company
- the business name and Australian Business Number (ABN)
- the address of the premises or base for mobile equipment
- the type of equipment located at the premises or base
- information about any provider not employed at, or contracted to provide services at the premises or base who has a financial interest in any of the equipment listed on the register.

Changes to primary information are recorded from the date a complete application is received or the date specified, whichever is later. An earlier date will only be considered if the application includes a signed request from the proprietor or authorised contact explaining the reason it is necessary to record an earlier date.

Your practice may also receive requests for information through Health Professional Online Services (HPOS), where this method of communication is available.

Renewing your registration

Each year we will remind you to confirm your LSPN record details to maintain registration.

If no changes are required to your LSPN record, you can renew using HPOS. If you do not respond on time, you will lose access to Medicare benefits. If you need to make changes to your LSPN record, you need to complete this form.

To renew through HPOS, go to **servicesaustralia.gov.au** and search for 'LSPN - HPOS User Guide'.

Signature and date requirements

Applications submitted:

- through HPOS by the person listed in the declaration do not need to be signed or dated.
- through HPOS by someone other than the person listed in the declaration must be physically signed and dated by the person making the declaration.
- by mail must be physically signed and dated.

Only the proprietor is authorised to sign the declaration for a new registration, including relocations.

For more information

Go to **servicesaustralia.gov.au/lspn** or call 1800 620 589 Monday to Friday, 8:30 am to 5 pm, Australian Eastern Standard Time.

Filling in this form

You can complete this form on your computer using Adobe Acrobat Reader, and some browsers, or you can print it.

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Do not use correction fluid or tape.
- Where you see a box like this ☐ ***Go to 1*** skip to the question number shown.

Application details

If you are renewing your registration and no changes are required to your LSPN record, you can renew using HPOS.

1 I would like to:

register for a new LSPN ☐ ***Go to 6***

amend, renew, relocate or close an existing LSPN ☐

2 LSPN

3 LSPN premises or base for mobile equipment address

Postcode

Provide a cover letter or HPOS message if advising about a minor address update.

4 I would like to:

close an existing LSPN ☐ ***Go to 5***

relocate a practice ☐ ***Go to 5***

update LSPN details ☐ ***Complete all questions relevant to your change(s)***

add or remove magnetic resonance imaging (MRI) providers ☐ ***Go to 39***

renew registration ☐ ***Go to 40***

5 Closure date (DD MM YYYY)

All active equipment will also be end dated.

If the practice is relocating, you must register for a new LSPN ▶ ***Go to 6***

If the practice is NOT relocating ▶ ***Go to 40***

6 Do you want the registration to begin on a specific date in the future?

If relocating, a start date is required. This cannot be the same as the closure date.

No ☐ Date of receipt will be the start date

Yes ☐ Start date (DD MM YYYY)

7 Are you registering a: **Tick one only**

premises ☐

base for mobile equipment ☐

If you are registering as a base for mobile equipment, you need to complete question 32.

8 Practice or mobile base trading name

If you are registering a hospital department, please state the name of the department (for example, Radiology Department or Radiology and Nuclear Medicine Department).

Business details

9 I would like to register changes to business or proprietor information to begin on

Start date (DD MM YYYY)

10 Registered business name
(as per the Australian Business Register)

11 ABN

12 What is the nature of your proprietorship?

Individual ☐ ***Go to 13***

Partnership ☐ ***Go to 14***

Company ☐ ***Go to 15***

Government agency or public body ☐ ***Go to 17***

Individual details

13 Family name

First given name ▶ ***Go to 18***

MCA0HW061 2406

Partnership details

14 Full name(s) of all partners

Partner/Company 1

Full name

ACN

Partner/Company 2

Full name

ACN

Partner/Company 3

Full name

ACN

If there are more than 3 partners, provide a separate sheet with details.

▶ *Go to 18*

Company details

15 Registered business name

16 ACN

▶ *Go to 18*

Government agency or public body details

17 Name of government agency (proprietor) of the practice or mobile base

Practice details

18 Which best describes the nature of this practice?

Tick one only

Group A
A private practice specialising in radiology, nuclear medicine and/or radiation oncology ☐ ▶ *Go to 19*

Group B
A general practice or private specialist medical practice (not included in Group A) ☐ ▶ *Go to 20*

Group C
Public facility ☐ ▶ *Go to 21*

19 Group A – A private practice specialising in radiology, nuclear medicine and/or radiation oncology

What best describes your practice type?

Tick one only

- Base for mobile equipment ☐
- Stand-alone practice (provides any of the above services) ☐
- Part of or co-located with a primary care practice or group ☐
- Part of or co-located with a private specialist medical centre ☐
- Co-located with a public hospital ☐
- Co-located with a private hospital ☐
- Private hospital ☐
- Private hospital co-located with a public hospital ☐
- Other (give details below) ☐

▶ *Go to 22*

20 Group B – A general practice or private specialist medical practice (not included in Group A)

What best describes your practice type?

Tick one only

- Base for mobile equipment ☐
- Primary care practice or group ☐
- Sports medicine clinic ☐
- Cardiology practice or group ☐
- Vascular surgery practice or group ☐
- Orthopaedic practice or group ☐
- Obstetric and gynaecological practice or group ☐
- Neurology or neurosurgery practice or group ☐
- Urology practice or group ☐
- Other (give details below) ☐

▶ *Go to 22*

21 Group C – Public facility

What best describes your practice type?

Tick one only

- Base for mobile equipment ☐
- Public Hospital—Campus (if you are registering more than one public hospital department, please tick this box) ☐
- Public Hospital—Radiology department ☐
- Public Hospital—Nuclear Medicine department ☐
- Public Hospital—Radiation Oncology department ☐
- Public Hospital—Cardiology department ☐
- Public Hospital—Vascular department ☐
- Public Hospital—Orthopaedic department ☐
- Public Hospital—Obstetrics and gynaecology department ☐
- Public Hospital—Neurology or neurosurgery department ☐
- Public Hospital—Urology department ☐
- Other (give details below) ☐

Practice location details

22 Location of premises or base for mobile equipment
(only complete this for new registrations)

Building/property name (if applicable)

Unit Suite Shop Floor number

Street number

Street name

Suburb

State Postcode

Primary authorised representative details

This section must be completed for partnerships, companies, government agencies and public authorities.

23 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

24 Daytime phone number (including area code)

Email

25 Position held

26 PRODA Registration Authority (RA) number

Access to HPOS will be linked for this LSPN. Once linked, HPOS will be the primary method of written communication with the practice.

If you are replacing an existing authorised representative, this person's administrator access in HPOS will be removed.

Secondary authorised representative details

27 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

28 Daytime phone number (including area code)

Email

29 Position held

30 PRODA RA number

Access to HPOS will be linked for this LSPN. Once linked, HPOS will be the primary method of written communication with the practice.

If you are replacing an existing authorised representative, this person's administrator access in HPOS will be removed.

Postal address

31 Is the postal address different to the practice premises?

No ☐

Yes ☐ Provide postal address

Postcode

Proprietor details for mobile base

32 Address for proprietors of mobile bases only
(this section must be completed)

Building/property name (if applicable)

Unit Suite Shop Floor number

Street number

Street name

Suburb

State Postcode

Equipment details

Before completing your equipment details

- Check all the equipment you will be listing. If there is not enough space to record all of your equipment, copy or print the relevant page for which you are providing details (for example, if you have more than 1 ultrasound, copy or print the required number of ultrasound pages you need).
- Tick the appropriate box for each type of equipment located at the premises or base for mobile equipment.
- Equipment used for more than one purpose must be listed under each equipment type separately.
- To advise us of changes to serial numbers or dates previously provided about equipment, include a separate letter explaining the details of the change.
- Upgrade dates must be within the effective life age of the equipment.
- All required details must be completed for each equipment type (unless it is not applicable) or your application will be returned as incomplete.

33 Complete the relevant question(s) with details of your equipment.

Ultrasound ☐ ***Go to 34***

Computed tomography ☐ ***Go to 35***

Nuclear medicine imaging (gamma camera) ☐ ***Go to 35***

Nuclear medicine imaging (PET scanner) ☐ ***Go to 35***

Diagnostic radiology (X-ray, mammography, fluoroscopy and orthopantamography equipment) ☐ ***Go to 35***

Magnetic resonance imaging (MRI) ☐ ***Go to 36***

Radiation oncology - megavoltage (linear accelerators) ☐ ***Go to 37***

Radiation oncology - megavoltage (simulators/localiser units) ☐ ***Go to 37***

Radiation oncology - megavoltage (CT interface computer/integrated network system) ☐ ***Go to 37***

Radiation oncology (brachytherapy) ☐ ***Go to 38***

Radiation oncology (kilovotage/orthovoltage and superficial units) ☐ ***Go to 38***

Radiation oncology (targeted intraoperative radiotherapy/electronic brachytherapy) ☐ ***Go to 38***

Once you have added all required details for your equipment ***Go to 40***

34 Ultrasound

Are you:

Tick one only

adding new or additional equipment ☐

changing existing equipment details ☐

Equipment type:

Doppler ☐

Non-Doppler ☐

With echocardiography?

No ☐

Yes ☐

Serial number

Model/type number

Manufacturer/company

It is mandatory to provide either the date manufactured **or** the date first installed.

Date manufactured (DD MM YYYY)
(for equipment that has previously been used outside Australia)

or

Date first installed in Australia (DD MM YYYY)
(for new equipment or equipment previously used in Australia)

Date upgraded (if applicable) (DD MM YYYY)

Date operational at premises (DD MM YYYY)
(only applicable if adding equipment from a future date)

Date removed (if applicable) (DD MM YYYY)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No ☐

Yes ☐ Name of provider or business

ABN (if applicable)

35 Diagnostic radiology/Nuclear medicine imaging/Computed tomography

Are you: **Tick one only**

adding new or additional equipment ☐

changing existing equipment details ☐

Tick the corresponding box of the diagnostic radiology unit you are registering

Tick one only

Angiography ☐ Fluoroscopy ☐

Mammography ☐ Orthopantamography ☐

X-ray ☐ Gamma camera ☐

PET ☐ CT gantry component (details of gantry only required) ☐

Serial number

Model/type number

Manufacturer/company

It is mandatory to provide either the date manufactured **or** the date first installed.

Date manufactured (DD MM YYYY)
(for equipment that has previously been used outside Australia)

or

Date first installed in Australia (DD MM YYYY)
(for new equipment or equipment previously used in Australia)

Date upgraded (if applicable) (DD MM YYYY)

Date operational at premises (DD MM YYYY)
(only applicable if adding equipment from a future date)

Date removed (if applicable) (DD MM YYYY)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No ☐

Yes ☐ Name of provider or business

ABN (if applicable)

36 Magnetic resonance imaging

Only MRI providers linked to an LSPN record are able to provide Medicare eligible MRI services. You can link MRI providers to your LSPN record by completing question 39 of this form.

Are you: **Tick one only**

adding new or additional equipment ☐

changing existing equipment details ☐

Eligibility type:

An MRI is Medicare eligible if it is part of a comprehensive practice and:

- eligibility has been granted by the Department of Health and Aged Care (DHAC) for practices located in Modified Monash (MM) 1, or
- the practice is located in MM 2 – 7.

If the equipment does not meet the above criteria, tick Medicare ineligible. For more information about MM locations, go to **health.gov.au**

Tick one only

Located in MM 1 and fully eligible for Medicare as granted by DHAC ☐

Located in MM 1 and partially eligible for Medicare as granted by DHAC ☐

Located in a comprehensive practice within MM 2-7 ☐

Medicare ineligible ☐

Magnetic strength (tesla units)

Serial number of magnet

Model/type number

Manufacturer/company

It is mandatory to provide either the date manufactured **or** the date first installed.

Date manufactured (DD MM YYYY)
(for equipment that has previously been used outside Australia)

or

Date first installed in Australia (DD MM YYYY)
(for new equipment or equipment previously used in Australia)

Date upgraded (if applicable) (DD MM YYYY)

Date operational at premises (DD MM YYYY)
(only applicable if adding equipment from a future date)

Date removed (if applicable) (DD MM YYYY)

Magnetic resonance imaging (continued)

Does any diagnostic imaging provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No ☐
Yes ☐ Name of provider or business

ABN (if applicable)

37 Radiation oncology - megavoltage

Linear accelerator/Simulator/Localiser units/CT interface computer/Integrated network system

Are you: **Tick one only**

adding new or additional equipment ☐
changing existing equipment details ☐

Equipment	**Tick one only**
Linear accelerator	Dual modality ☐
	Single photon linear ☐
Simulator/Localiser unit	With CT ☐
	Without CT ☐
CT interface computer	☐
Integrated network system	☐

Serial number

Model/type number

Manufacturer/company

Number of workstations
(CT interface computers only)

Does this linear accelerator have any or all of the following additional features?

MLC
No ☐
Yes ☐

EPI
No ☐
Yes ☐

Date operational at premises (DD MM YYYY)
(only applicable if adding equipment from a future date)

Date removed (if applicable) (DD MM YYYY)

Linear accelerator/Simulator/Localiser units/CT interface computer/Integrated network system (continued)

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No ☐
Yes ☐ Name of provider or business

ABN (if applicable)

38 Radiation Oncology

Brachytherapy/Kilovoltage/Targeted intraoperative radiotherapy

Are you: **Tick one only**

adding new or additional equipment ☐
changing existing equipment details ☐

Equipment	**Tick one only**
Brachytherapy	Autoafter-loading ☐
	Manually loaded ☐
Kilovoltage	Orthovoltage ☐
	Superficial unit ☐
Targeted intraoperative radiotherapy	
	Electronic brachytherapy ☐

Serial number

Model/type number

Manufacturer/company

Date operational at premises (DD MM YYYY)
(only applicable if adding equipment from a future date)

Date removed (if applicable) (DD MM YYYY)

Does any radiation oncology provider or group of providers not employed or contracted to provide services at or from this practice have a financial interest in the above equipment?

No ☐
Yes ☐ Name of provider or business

ABN (if applicable)

Providers of Medicare-eligible magnetic resonance imaging services

39 Complete the following for all who perform or no longer perform Medicare-eligible MRI services on your Medicare-eligible MRI unit.

The authorised representative completing this form has confirmed that the providers listed are specialists in diagnostic radiology and are:

- a participant in the Royal Australian and New Zealand College of Radiologists Quality and Accreditation Program, **and**
- a provider of Medicare rebateable MRI services on the MRI Scanner located at the LSPN noted below, **or**
- to be removed from their linked LSPN.

Radiologists

Provider number	Provider name (name of each provider at the practice)	Remove
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

If you need more space for providers to be added or removed on a specific date, provide a separate sheet with details.

Privacy notice

40 The privacy and security of your personal information is important to us, and is protected by law. We collect this information to provide payments and services. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacypolicy**

Declaration for registrations and amendments

Only the proprietor is authorised to sign the declaration for a new registration, including relocations.

If amending the authorised representative details, only the proprietor or the registered authorised representative can sign the declaration.

For a closure, relocation or change of ownership, the proprietor/ authorised representative of the LSPN being closed or of the outgoing company in a change of ownership must sign the **Declaration for registration closures**.

41 **I declare that**:

- I have the appropriate authority to sign this document in my capacity as:
  - Proprietor ☐
  - Authorised representative ☐
- I will not assume this application has been processed until I have received confirmation.
- the information I have provided in this form is complete and correct.

I understand that:

- dates of effect for new registrations and listing new equipment on my LSPN record will not be earlier than the date a complete and correct application is received.
- I must comply with the requirements as set out in the *Health Insurance Act 1973*.
- I should retain a copy of this form for my records.
- giving false or misleading information is a serious offence.

☐ I have read, understood and agree to the above.

Full name of person making declaration

Date (DD MM YYYY)

Signature (**only** required if returning by post or if someone other than the person named submits this form through HPOS)

If required, print and sign by hand.

For more information on when to sign and date this form, refer to **Signature and date requirements** on page 1 of this form.

Declaration for registration closures

Only the proprietor or the registered authorised representative of the LSPN being closed or of the outgoing company in a change of ownership can sign this declaration.

42 I declare that:

- I have the appropriate authority to sign this document in my capacity as:
  - Proprietor ☐
  - Authorised representative ☐
- the information I have provided in this form is complete and correct.

I understand that:

- I must comply with the requirements as set out in the *Health Insurance Act 1973*.
- I should retain a copy of this form for my records.
- giving false or misleading information is a serious offence.

☐ I have read, understood and agree to the above.

Full name of person making declaration

Date (DD MM YYYY)

Signature (**only** required if returning by post or if someone other than the person named submits this form through HPOS)

If required, print and sign by hand.

For more information on when to sign and date this form, refer to **Signature and date requirements** on page 1 of this form.

Returning this form

STOP

Check that you have answered all the required questions and provide the requested documentation when you return this form. If the application is incomplete or incorrect, it will be returned and you will need to re-apply.

Return all pages of the completed form and supporting documents:

- **online**, using your PRODA account and the Form upload function in HPOS. For more information, go to **servicesaustralia.gov.au/hpos**
- by post (signature required) to

  Services Australia
  Provider Registration Section
  GPO Box 9822
  In your capital city

Reset form