



# Application to register or amend Approved Billing Agent details (HW015)

## When to use this form

Use this form:

- to register as an Approved Billing Agent (for submitting Inpatient Medical Claims only)
- if you are an existing Approved Billing Agent wanting to update your Billing Agent details, or
- if you are an existing Approved Billing Agent wanting to add ECLIPSE functions.

For new Approved Billing Agent registration, complete all sections of the form and submit with relevant documents as listed on our website [servicessaustralia.gov.au/billingagent](http://servicessaustralia.gov.au/billingagent)

## Who should use this form

**Corporation** – application to be completed by 2 authorised representatives of the company. Where the applicant is a proprietary company, with a sole director who is also the sole company secretary, this application must be completed by that person.

**Partnership** – application to be completed by all partners of a partnership. The partners are the persons who have effective control of the management of the Approved Billing Agent.

**Individual** – application to be completed by the individual who is applying to be an Approved Billing Agent.

**State or territory government or other public body** – application to be completed by an authorised representative of the proprietor of the proposed Approved Billing Agent. The proprietor is the person or authority who has effective control of the Approved Billing Agent.

## For more information

For more information about Approved Billing Agents, go to [servicessaustralia.gov.au/billingagent](http://servicessaustralia.gov.au/billingagent)

If you need assistance completing this form, email [DCM.support@servicessaustralia.gov.au](mailto:DCM.support@servicessaustralia.gov.au)

There may be risks with sending personal information through unsecured networks or email channels.

If you need assistance with ECLIPSE, call **1800 700 199** Monday to Friday, 8:30 am to 5 pm, Australian Eastern Standard Time.

Call charges may apply.

## Filling in this form

You can complete this form on your computer, print and sign it.

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this  Go to 1 skip to the question number shown.

## Applicant's details

**1** Approved Billing Agent registration number (if existing)

**2** Reason for application

I would like to:

**Tick one only**

register to become an

Approved Billing Agent  Go to next question

update an existing Approved

Billing Agent registration  Go to next question

add ECLIPSE to an Approved

Billing Agent registration  Go to 12

**3** Indicate the category that applies to you:

**Tick one only**

Corporation

Partnership

Individual

State or territory government or other public body

**4** Registered name of Approved Billing Agent

**5** Trading name

**6** Approved Billing Agent address

  


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 Postcode

**7** Postal address (if different to above)

Postcode

Business phone number

Fax number

Email

**8** Australian Business Number (ABN)

**Location details**

**9** Is data currently being transmitted for other Services Australia programs?

No

Yes  Indicate the Location ID

The Minor ID number can be your Billing Agent registration number.

**10** Will you be using this number for Simplified Billing/ECLIPSE claims?

No  Indicate the Minor ID you wish to use

Yes

**Participation in ECLIPSE**

**11** Would you like to participate in ECLIPSE?

No  **Go to 17**

Yes

**12** Location name

**13** Location ID

**14** Site certificate Registration Authority (RA) number

The Location ID and RA number can be obtained by contacting Services Australia on **1800 700 199**.

**15** Anticipated implementation date

**16** Are you registering for ECLIPSE using a current registration number only?

No

Yes

**Authorised contact person's details**

**17** Authorised contact person's name

The authorised contact person is anyone who is authorised, on behalf of the Billing Agent(s) named in this form, to contact us **only** for enquiries.

Dr  Mr  Mrs  Miss  Ms  Other

Family name

First given name

Second given name

Position held

**18** Business phone number

Fax number

Email

**Trust account details**

All payments are made through Electronic Funds Transfer (EFT) and cannot be made into credit card, loan or mortgage accounts.

**19** Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Trust account name

Payment times are in accordance with the Australian Government's **minimum payment of 10 days** from date of lodgement to a trust account registered with Services Australia.

## Privacy notice

- 20** The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. 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/privacy](https://servicesaustralia.gov.au/privacy)

## Declaration

If the Approved Billing Agent is managed by:

- a **corporation**, either 2 authorised representatives of the company or the company proprietor are required to sign this form.
- a **partnership**, all partners are required to sign this form.
- an **individual**, that individual (the applicant) who is applying to be an Approved Billing Agent needs to sign this form.
- a **state or territory government or other public body**, an authorised representative of the proprietor is required to sign this form.

## 21 I am/We are:

- authorised representative(s) of a company applying to be an Approved Billing Agent.
- a partner of a partnership applying to be an Approved Billing Agent.
- an individual applying to be an Approved Billing Agent.
- an authorised representative of the proprietor of a state or territory government or other public body.

### I/We understand that:

- this form is approved under subsection 20AB of the *Health Insurance Act 1973*.
- giving false or misleading information is a serious offence.

### I/We declare that:

- I/We will advise Services Australia, **within 14 days**, of any changes to the Approved Billing Agent's trust account details or other relevant information.
- the information I have provided in this form is complete and correct.

## Applicant/Authorised representative/Partner 1

Full name

Position held

Signature

Date

## Applicant/Authorised representative/Partner 2

Full name

Position held

Signature

Date



If more than 2 signatures are required, provide a separate sheet with details.

## Returning this form

Return this form and any supporting documents:

- **by email to:** [DCM.support@servicesaustralia.gov.au](mailto:DCM.support@servicesaustralia.gov.au)  
There may be risks associated with sending personal information through unsecured networks or email channels.
- **by post to:**  
Services Australia  
Digital Channel Management Section  
PO Box 1001  
TUGGERANONG DC ACT 2901

## Office use only

Billing Agent registration number

Approved

Not approved

Signature

Date