Instructions

Australian Government
Services Australia

medicare

Register for or amend a Location Specific Practice Number (HW061)

When to use this form

Use this form to register, amend, renew, relocate or close a Location Specific Practice Number (LSPN). A registration form is required for each practice site and must be signed by a proprietor or authorised representative.

A LSPN is location specific. If a registered site is sold or is moving physical location, you can also use this form to advise us of the relocation.

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

Your Location Specific Practice Number

- A LSPN will be allocated to your practice site or mobile facility on submission of a completed registration form.
- The LSPN will be activated from the date received by us or a future date if requested.
- We will write to your practice to confirm your registration and advise you of your site's LSPN.
- Registered sites and their allocated LSPN will be published on our website **servicesaustralia.gov.au/LSPN**

Maintaining your registration

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

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

Failure to notify us of changes to primary information on the LSPN register can result in suspension or cancellation of the registration for the practice site or mobile base. If a practice is over the 28 day period and has not contacted us, claims may not be paid.

For more information

Go to **servicesaustralia.gov.au/LSPN** or call **1800 620 589** Monday to Friday, 7:30 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.

This application will be considered incomplete if not signed.

Forms submitted via Health Professional Online Services (HPOS) may be signed manually or appended with a digital signature.

Forms submitted via post or fax must be manually signed only.

Application type

1 I would like to:

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

Register for a new LSPN as part of a relocation or takeover ☐ ***Go to 2***

Amend an existing LSPN ☐ ***Go to 2***

Renew an existing LSPN ☐ ***Go to 2***

Close an existing LSPN ☐ ***Go to 2***

Add MRI providers ☐ ***Go to 45***

2 Existing LSPN

3 LSPN practice site or base for mobile equipment address

Postcode

4 Are you closing the LSPN and removing all equipment?

No ☐ ***Go to 5***

Yes ☐ Closure date

/ /

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

If the practice is NOT relocating or changing ownership ***Go to 48***

5 Do you have any changes to your LSPN?

No ☐ ***Go to 47***

Yes ☐ Complete all questions relevant to your change(s). You will need to register for a new LSPN if there are changes to ownership or location.

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

No ☐

Yes ☐ Start date

/ /

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

Practice site ☐

Base for mobile equipment ☐

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

8 Practice site or mobile facility 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 Registered business name

10 Australian Business Number (ABN)

11 What is the nature of your proprietorship?

Individual ☐ ***Go to 12***

Partnership ☐ ***Go to 13***

Company ☐ ***Go to 14***

Government agency or public body ☐ ***Go to 16***

Individual details

12 Family name

First given name

Go to 18

Partnership details

13 Full name(s) of all partners

Partner/Company 1

Full name

Australian Company Number (ACN)

Partner/Company 2

Full name

ACN

Partner/Company 3

Full name

ACN

Partner/Company 4

Full name

ACN

If there are more than 4 partners, provide a separate sheet with details.

Go to 18

Company details

14 Registered business name

15 ACN

Go to 18

Government agency or public body details

16 Name of government agency (proprietor) of the practice site or mobile facility

17 ACN

Practice site 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 site type?

Tick one only

- Base for mobile equipment ☐
- Stand-alone practice site (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 site 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 site 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 practice site 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

( )

Fax number

( )

Email

25 Position held

26 Would you like the authorised representative to be linked to Health Professional Online Services (HPOS) for this LSPN?

No ☐

Yes ☐ ▶ Provider Digital Access (PRODA) or Public Key Infrastructure (PKI) reference

Secondary authorised representative details

27 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

28 Daytime phone number

( )

Fax number

( )

Email

29 Position held

30 Would you like the authorised representative to be linked to Health Professional Online Services (HPOS) for this LSPN?

No ☐

Yes ☐ PRODA/PKI reference

Postal address

31 Is the postal address different to the practice site address?

No ☐

Yes ☐ Provide postal address

Postcode

Mobile proprietor's details

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 the number of units you will be registering. If there is insufficient space to record all of your units, photocopy the relevant page for which you are providing details (for example, if you have more than 2 ultrasound units, photocopy the required number of ultrasound pages you need)
- attach any additional equipment details to the back of this form
- tick the appropriate box for each type of equipment located at this practice site or base for mobile equipment.

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 36***

Nuclear Medicine Imaging (PET scanner) ☐ ***Go to 37***

Diagnostic Radiology (X-ray, Mammography, Fluoroscopy and Orthopantamography equipment) ☐ ***Go to 38***

Magnetic Resonance Imaging (MRI) ☐ ***Go to 39***

Radiation Oncology (Linear accelerators) ☐ ***Go to 40***

Radiation Oncology (Brachytherapy) ☐ ***Go to 41***

Radiation Oncology (Cobalt units) ☐ ***Go to 42***

Radiation Oncology (Simulators/Localiser units) ☐ ***Go to 43***

Radiation Oncology (CT interface planning computers) ☐ ***Go to 44***

Once you have completed your equipment list(s) ***Go to 47***

34 Ultrasound

Ultrasound unit 1

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

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

/ /

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

/ /

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

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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

Australian Business Number (ABN) (if applicable)

– – –

Ultrasound unit 2

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

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

/ /

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

/ /

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

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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

Australian Business Number (ABN) (if applicable)

– – –

35 Computed Tomography

CT Gantry component (details of gantry only required)

Are you:

Tick one only

Adding new or additional equipment ☐

Changing existing equipment details ☐

Serial number

Model/type number

Manufacturer/company

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

/ /

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

/ /

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

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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 Nuclear Medicine Imaging

Gamma Camera

Are you:

Tick one only

Adding new or additional equipment ☐

Changing existing equipment details ☐

Serial number

Model/type number

Manufacturer/company

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

/ /

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

/ /

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

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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 Nuclear Medicine Imaging

PET

Are you:

Tick one only

Adding new or additional equipment ☐

Changing existing equipment details ☐

Serial number

Model/type number

Manufacturer/company

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

/ /

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

/ /

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

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

38 Diagnostic radiology

Diagnostic radiology unit 1

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 ☐

Serial number

Model/type number

Manufacturer/company

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

/ /

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

/ /

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

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

– – –

Diagnostic radiology unit 2

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 ☐

Serial number

Model/type number

Manufacturer/company

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

/ /

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

/ /

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

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

– – –

39 Magnetic Resonance Imaging (MRI)

Only MRI providers registered to an LSPN are able to provide Medicare eligible MRI services. You can register MRI providers to your LSPN by completing question 45 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 has been deemed eligible by the Department of Health. If the MRI has not been approved by the Department of Health as eligible please tick Medicare ineligible.

Medicare eligible ☐
Medicare partially eligible ☐
Medicare ineligible ☐

Magnetic strength (tesla units)

Serial number of magnet

Model/type number

Manufacturer/company

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

/ /

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

/ /

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

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

– – –

40 Radiation Oncology

Linear accelerator

Are you:

Tick one only

Adding new or additional equipment ☐
Changing existing equipment details ☐

Dual modality ☐
Single photon linear ☐

Serial number

Model/type number

Manufacturer/company

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

MLC
No ☐
Yes ☐

EPI
No ☐
Yes ☐

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

– – –

41 Radiation Oncology

Brachytherapy

Are you:

Tick one only

Adding new or additional equipment ☐

Changing existing equipment details ☐

Autoafter-loading ☐

Manually loaded ☐

Serial number

Model/type number

Manufacturer/company

Date upgraded (if applicable)

/ /

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

42 Radiation Oncology

Cobalt unit

Are you:

Tick one only

Adding new or additional equipment ☐

Changing existing equipment details ☐

Serial number

Model/type number

Manufacturer/company

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

43 Radiation Oncology

Simulator/Localiser unit

Are you:

Tick one only

Adding new or additional equipment ☐

Changing existing equipment details ☐

With CT ☐

Without CT ☐

Serial number

Model/type number

Manufacturer/company

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

44 Radiation Oncology

CT interface planning computers

Are you:

Tick one only

Adding new or additional equipment ☐

Changing existing equipment details ☐

Serial number

Model/type number

Manufacturer/company

Number of workstations

Date operational at site
(only applicable if adding equipment from a future date)

/ /

Date removed (if applicable)

/ /

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)

Providers of Medicare-eligible Magnetic Resonance Imaging Services

45 Complete the following for all who perform Medicare-eligible Magnetic Resonance Imaging (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.

Radiologists

LSPN number

Registered business name

Practice address

Postcode

Provider number	Provider name (name of each provider at the Practice)

If you need more space, provide a separate sheet with details.

Privacy notice

46 Your 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/privacy**

Declaration for LSPN registrations and amendments

47 **I hereby apply/amend/renew my registration**:

- for a Location Specific Provider Number for the practice site or base for mobile equipment described in this form.

I understand that:

- Services Australia may request more information regarding details on this registration form from the proprietor or authorised representative nominated on this form.
- I must notify Services Australia of any changes to this information **within 28 days** of the change(s) occurring.
- giving false or misleading information is a serious offence.

I declare that:

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

Proprietor ☐

Authorised representative ☐

For partnerships, companies, government agencies and public bodies, an authorised representative must be nominated.

Full name

Position held

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

Signature

On completion, print and sign by hand.

Date

/ /

Company seal

Declaration for LSPN registration closures

48 **I hereby cancel my registration**:

- for a Location Specific Provider Number for the practice site or base for mobile equipment described in this form.

I understand that:

- Services Australia may request more information regarding details on this registration form from the proprietor or authorised representative nominated on this form.
- giving false or misleading information is a serious offence.

I declare that:

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

Proprietor ☐

Authorised representative ☐

For partnerships, companies, government agencies and public bodies, an authorised representative must be nominated.

Full name

Position held

Only the proprietor or the registered authorised representative of the LSPN being cancelled can sign this declaration.

Signature

On completion, print and sign by hand.

Date

/ /

Company seal

Checklist

49 Check the following:

For New LSPN registration and relocation/change of ownership

Have you ticked whether you are registering a practice site or a base for mobile equipment? (**question 7**) ☐

Have you ticked the nature and type of practice? (**question 18**) ☐

Have you provided all the details required in the equipment list? (**question 33-44**) ☐

Have you signed the Declaration for LSPN registrations and amendments? (**question 47**) ☐

For relocations/change of ownership, has the proprietor/ authorised representative of the closing LSPN signed the Declaration for LSPN closures? (**question 48**) ☐

If applicable, have you photocopied and completed extra equipment pages and attached to this form? ☐

Have you taken a copy of the registration form for your records? ☐

For LSPN amendments

Have you identified the LSPN details? (**questions 1-5**) ☐

If applicable, have you provided all the details required in the equipment list? (**question 33-44**) ☐

Have you signed the Declaration for LSPN registrations and amendments? (**question 47**) ☐

If applicable, have you photocopied and completed extra equipment pages and attached to this form? ☐

Have you taken a copy of the registration form for your records? ☐

For LSPN closures

Have you identified the LSPN details and closure date? (**questions 1-4**) ☐

Have you signed the Declaration for LSPN closures? (**question 48**) ☐

Have you taken a copy of the registration form for your records? ☐

Returning this form

Return this form and any supporting document(s):

- **online**, upload through Health Professional Online Services (HPOS) at **servicesaustralia.gov.au/hpos**
- by post to:
  Services Australia
  Provider Liaison Section
  GPO Box 9822
  PERTH WA 6847
- by fax to: **08 9214 8201**

Reset form Print form