MEDICAL BUSINESS MANAGEMENT

MBM REGISTRATION FORM

PROVIDER DETAILS				
NAME:			DATE OF BIRTH	
PROVIDER NUMBER: PROVIDER NUMBER LOCATION ADDRESS:				
TELEPHONE	HOME: MOBILE: FACSIMILE:			
EMAIL ADDRESS				
BANKING DETAILS	A/C NAME:			
BANK		BRANCH		
BSB		ACCOUNT		
CREDENTIALS (FOR INV.HEADER)		ADDITIONAL INFO (eg no gap pensioners only)		
ABN/ACN NUMBER				
NO GAP Y/N	UNIT RATE $			
PRICING OPTION (PLEASE TICK)				
OPTION A	OPTION B	OPTION C	OPTION D	
OPTIONAL EXTRA'S (PLEASE TICK)	BPAY	ONLINE C/CARD	ECLIPSE	
REPORTING (PLEASE TICK)	WEEKLY	MONTHLY	FAX	
			EMAIL	

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(PLEASE SIGN) (DATE)

PLEASE NOTE – COPY OF CURRENT MEDICAL IDEMNITY INSURANCE WILL NEED TO BE PROVIDED.

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