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	$		

…… ……

(PLEASE SIGN) (DATE)

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

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