

Application for Provider Number for a Dental Specialist

Instructions for completing this Application

- Is this your **first application** for a Medicare provider number?
YES - Complete all sections 1 - 6
NO - Complete sections 1, 2, 5 and 6

Additional copies of this application can be obtained by downloading from the HIC web site www.hic.gov.au or telephoning Provider enquiries on 132 150

This application will be returned if all relevant documentation/information has not been supplied

1. Personal details

Family name First name Date of birth Sex

Please quote **any** existing provider number issued to you

Contact telephone number (*during business hours*)

2. Mailing address (*used for correspondence about provider number information*)

Number and Name of Street/PO Box/Bag No.:

Town/Suburb: State: Postcode:

3. Qualifications

Professional qualification Place obtained Year obtained

Languages spoken (*other than English*)

4. Registration membership details (*You must have current board registration or association membership for any State or Territory in which you practise*)

State or Territory	Registration Number	Date Registered	Name of Board or Association

Please supply a certified copy of documents confirming registration/membership of any State or Territory Professional Board or Association.

5. Required Practice locations

Practice location: A practice location is its physical location (*not post office box*) and is the address at which you render services.

Practice 1	Start date / / End date / / <i>(if required)</i>	Practice or Hospital Name Building/Suite No./Department Street Details Locality/Suburb State Postcode Contact Telephone Number <i>(include STD code)</i>
-------------------	--	---

Practice 2	Start date / / End date / / <i>(if required)</i>	Practice or Hospital Name Building/Suite No./Department Street Details Locality/Suburb State Postcode Contact Telephone Number <i>(include STD code)</i>
-------------------	--	---

Attach a list if additional practice locations are required

Please **close** the following provider numbers:

Provider Number	Address	Closing Date
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

6. Declaration

I declare that, to the best of my knowledge and belief, all the information provided on this application form is true and correct.

Signature of applicant ----- Date ____/____/____

Privacy Note: Information provided by you on this form will be used to allocate a provider number that will enable you to participate in the Medicare program. Its collection is authorised by law and may be disclosed to the Department of Health and Aged Care. Some details are released on a regular basis to private health funds and other approved organisations, to assist with the payment of benefits. Such releases are authorised by law.

Lodgement details:

When completed your application may be posted to:

HIC Provider Liaison Section
PO Box 9822 (in your capital city)

OR:

Your application can be sent by facsimile to:

- NSW and ACT 02 9895 3439
- VIC 03 9605 7984
- QLD 07 3004 5408
- SA and NT 08 8274 9307
- WA 08 9214 8201
- TAS 03 6215 5700

Please note:

- The application and supporting documentation should be submitted to HIC at least 14 working days prior to your proposed commencement date.
- Regardless of whether you elect to post or fax your application, you are still required to mail certified copies of the original documents to the Provider Liaison Section at the above address.
- If you elect the fax option, please include a covering note to advise your name, address, date application was faxed and what type of provider application you have applied for, when mailing the supporting documentation.
- Where applications are faxed, you must retain your original documents for auditing purposes.

Provider Enquiries: Telephone 132 150 (9.00am to 4.30pm) or e-mail medicare.prov@hic.gov.au

Please provide an estimate of the time taken to complete this form

hrs • min