Frequently Asked Questions: Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative

Medicare benefits are available to eligible people for mental health treatment under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative* (Better Access). This factsheet seeks to provide answers to frequently asked questions regarding the Better Access Initiative, including changes that commenced on 1 November 2025.

Better Access initiative

Services

What Medicare services are provided under the Better Access initiative?

Under the Better Access initiative, eligible patients can claim Medicare benefits for selected mental health treatment services if they have been assessed as having a clinically diagnosed mental disorder requiring at least a moderate level of support and have:

- a referral from a General Practitioner (GP) or Prescribed Medical Practitioner (PMP) as part of a GP Mental Health Treatment Plan (MHTP) or a psychiatrist assessment and management plan (PAMP), or
- a direct referral from a psychiatrist, or
- a direct referral from a paediatrician.

Eligible patients can receive up to 10 individual and up to 10 group mental health treatment services per calendar year (1 January to 31 December) which include psychological therapy services provided by eligible clinical psychologists and focussed psychological strategies services provided by eligible GPs, eligible PMPs, eligible psychologists (registered), eligible social workers and eligible occupational therapists.

Psychiatrists and paediatricians can directly refer eligible patients with a clinically diagnosed mental disorder to Better Access mental health treatment services without a MHTP or a PAMP.

Further information is available in the Better Access Initiative resource collection or explanatory note AN.0.78 which provides an overview of the Better Access initiative on MBS Online.

Can patients access Better Access services if they live in a Residential Aged Care Facility?

Medicare benefits are available for up to 10 individual and up to 10 group therapy mental health services per calendar year to patients with an assessed mental disorder living in a Residential Aged

Care Facility (RACF). Referral options to Better Access services will depend on a patient's circumstances.

Commonwealth-funded residents living in a RACF must receive a direct referral from a psychiatrist for mental health treatment services delivered by eligible general practitioners, eligible prescribed medical practitioners, eligible clinical psychologists, eligible registered psychologists, eligible social workers and eligible occupational therapists under the Better Access Initiative.

How many mental health treatment services do patients receive under Better Access?

Through Better Access, eligible patients can claim a Medicare benefit for up to 10 individual and up to 10 group therapy mental health treatment services per calendar year (1 January to 31 December) if they have been assessed with a clinically diagnosed mental disorder and have a valid referral.

The maximum limit for each individual course of treatment is:

- Initial course of treatment services under Better Access – a maximum of 6 services, and
- Subsequent course of treatment services under Better Access – the remaining services up to a cap of 10 services per calendar year.

In addition to individual mental health treatment services, eligible patients may also claim up to 10 separate group therapy mental health treatment services.

Further information is available in explanatory note AN.0.78 which provides an overview of the Better Access initiative on MBS Online.

If a patient has not used all their services in a calendar year, can they be used the following calendar year?

Where the number of mental health treatment services shown on the referral are not used by the end of the calendar year, the remaining mental health treatment services on the referral will be valid for use in the next calendar year. However, any mental health treatment services used in the next calendar year count to the maximum cap of services per calendar year.

What happens when a patient exhausts all Better Access treatment services for year?

Patients will not receive a Medicare benefit for Better Access services which exceed the maximum allocation of 10 individual and 10 group therapy services in a calendar year.

However, if a patient has appropriate private health insurance which covers psychological services, they may be able to claim any additional services from their private health insurer, depending on their level of ancillary cover. They can also choose to cover the entire out-of-pocket cost for any additional services.

If a patient has utilised all their Better Access mental health treatment services in a calendar year and require more, they can talk to their general practitioner or prescribed medical practitioner and / or their treating allied health professional about other alternative options available, including services available through Primary Health Networks (PHNs) and Medicare Mental Health Centres.

To find a local PHN and what services may be available to a patient in that region, they can go to www.health.gov.au/phn and use the map locator to search their postcode. For more information

on Medicare Mental Health Centres, Patients can make a free call to the Medicare Mental Health Phone Service on 1800 595 212 or visit the Medicare Mental Health Centre website at Medicare Mental Health.

Where can patients find further information about the Better Access initiative?

Further information on the Better Access initiative can be found on the Department's website: Better Access Initiative resource collection and by searching 'Better Access' on MBS Online.

Mental Health Treatment Plans, Referrals and Reviews

How does a patient get a Mental Health Treatment Plan and a referral for Better Access services?

To obtain a Mental Health Treatment Plan (MHTP), patients need to visit their general practitioner (GP), prescribed medical practitioner (PMP), psychiatrist or paediatrician who will assess if they have a mental disorder which requires at least a moderate level of support and if Better Access mental health treatment services are appropriate for them.

To be eligible for a Medicare benefit, a patient's MHTP for mental health treatment services must have been undertaken by either a GP or PMP at the general practice they are enrolled in for MyMedicare, or their usual medical practitioner. A usual medical practitioner includes a GP or PMP who is located at the medical practice that has provided the majority of a patient's care over the previous 12 months or will be providing the majority of care over the next 12 months. This restriction does not apply if a patient has received a direct referral from a psychiatrist or a paediatrician - in this case, a patient can still claim a Medicare benefit.

Once a patient's eligibility to receive Better Access services has been determined, a MHTP will be prepared along with a referral. These services are generally provided in 2 courses of treatment per year (if required). The referring practitioner will decide how many services the patient will receive in a course of treatment, within the maximum service limit for the course of treatment. The maximum service limit for each individual course of treatment is set out below:

- Initial course of treatment - a maximum of 6 services.
- Subsequent course of treatment - a maximum of 6 services up to the patient's cap of 10 services per calendar year (for example, if the patient received 6 services in their initial course of treatment, they could only receive 4 services in a subsequent course of treatment provided within the same calendar year).

A patient must return to their referring practitioner (GP, PMP, psychiatrist or paediatrician) who will assess if the patient needs a subsequent course of treatment.

A referring practitioner may also advise that in addition to individual services, a patient may like to attend group therapy mental health treatment services, if appropriate, where up to 10 patients can be in attendance. Group therapy offers a structured and empathetic setting where patients can share personal experiences and connect with others facing similar challenges, fostering mutual support. A referral for group therapy mental health services can be written for up to a maximum of 10 services on one referral per calendar year.

Further information is available in the Better Access Initiative resource collection or explanatory note AN.0.78 which provides an overview of the Better Access initiative on MBS Online.

Do Mental Health Treatment Plans need to be prepared every time a new referral for mental health treatment services is required?

A new Mental Health Treatment Plan (MHTP) should not be created unless exceptional circumstances exist.

An exceptional circumstance may be where the patient has had a significant change to their mental health or the treating practitioner is unable to obtain a copy of their MHTP.

While a MHTP does not have an expiry date, patients should be aware that their eligibility for support under the Better Access initiative may change over time. Recovery from a mental health disorder does not preclude future eligibility for further support if required. If a patient requires support later, a review of their MHTP and referral for treatment may be sufficient.

Can patients discuss any physical health care requirements when they attend an appointment with their GP or PMP to discuss their mental health?

When a new Mental Health Treatment Plan (MHTP) is prepared for a patient, the general practitioner (GP) or prescribed medical practitioner (PMP) will prepare the plan using dedicated Medicare Benefit Schedule (MBS) item numbers. In this instance, a patient may be asked to make another appointment should they require discussion on their physical health.

When patients see their GP or PMP for a review of their MHTP, a referral for mental health treatment services, or ongoing mental health care, time-tiered professional (general attendance) MBS item numbers will apply. These item numbers allow patients to discuss both physical and mental health needs, with different billing tiers based on the length of the consultation.

Can a GP or PMP at headspace also undertake a Mental Health Treatment Plan?

For a Medicare benefit to be payable, usual medical practitioner arrangements may apply to services provided by a general practitioner or a prescribed medical practitioner through headspace for Mental Health Treatment Plan (MHTP) preparation, referrals for mental health treatment services, and reviews of a patients MHTP.

Does the allied health professionals name need to be on the referral?

A referral must have the name of the allied health professional on it, even if the patient chooses to see a different allied health professional within that same specialty. If the patient chooses to see a different allied health professional within that speciality, it is not necessary for the patient to revisit their general practitioner or prescribed medical practitioner to obtain a new referral.

Can patients find out how many Better Access services they have left for the calendar year or are left on their referral?

Yes. Patients can check with their general practitioner or prescribed medical practitioner or ask their allied health professional how many services they have remaining on their referral.

Alternatively, a patient can seek clarification on the number of services they have remaining in the calendar year by calling 132 011 or they can view their care plan history in their Medicare online account through myGov.

How often does a Mental Health Treatment Plan need to be reviewed?

After a patient has used the referred number of services in the initial individual course of treatment, a review of the patient's mental health treatment and a new referral must be obtained from the referring practitioner. This review should assess the patient's progress, confirm the appropriateness of the treatment plan, and allow for any necessary adjustments to care. The review will assess the patient's progress and is not to be undertaken:

- more than once in a three-month period, or
- within four weeks following the preparation of a Mental Health Treatment Plan (MHTP), unless exceptional circumstances exist. An exceptional circumstance is when a patient has had a significant change in their mental health condition.

It is recommended that a Mental Health Treatment Plan be reviewed at least once at the end of a course of treatment, with most patients generally not requiring more than 2 reviews in a calendar year.

General practitioners (GPs) and prescribed medical practitioners (PMPs) are to use time-tiered professional (general attendance) item numbers for the specific purpose of reviewing a MHTP, referring a patient for mental health treatment services and providing ongoing mental health consultations. Further information is available in explanatory note AN.0.56 on MBS Online.

How will Services Australia oversee usual medical practitioner requirements if a patient does not have to see their original referring practitioner for reviews of a Mental Health Treatment Plan or a new referral?

Flexibility has retained and been built into the Services Australia system for the Better Access initiative to allow patients to be able to see different referring practitioners for review and further referrals for mental health treatment services under usual medical practitioner requirements.

All general practitioners (GPs), prescribed medical practitioners (PMPs) and allied health professionals providing Better Access services should ensure they keep adequate and contemporaneous records, including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records

Requirements of general practitioner prescribed medical practitioner and allied health professionals providing mental health treatment services

Can any general practitioner, prescribed medical practitioner or allied health professional provide mental health treatment services under the Better Access initiative?

No. Psychological therapy services can only be provided by eligible clinical psychologists and focussed psychological strategies services can only be provided by eligible general practitioners (GPs), eligible prescribed medical practitioners (PMPs), eligible psychologists (registered), eligible social workers and eligible occupational therapists.

Further information on eligibility requirements to provide mental health treatment services under the Better Access initiative can be found in:

- Explanatory notes MN.6.2 and MN.7.4 on MBS Online.
- Schedule 1 (Qualification requirements for allied health professionals) in the *Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024*.
- Clause 2.20.7 (Restrictions on items in Subgroup 2 of Group A 20) and Clause 2.20.7A (Restrictions on items in Subgroup 9 of Group A7) in the *Health Insurance (General Medical Services Table) Regulations 2021* for GPs and PMPs.

Can a patient see a general practitioner (GP) or prescribed medical practitioner (PMP)to receive a mental health treatment service?

Yes. Focussed psychological strategies services are available to any patient with a Mental Health Treatment Plan (MHTP) from any eligible general practitioner (GP) and eligible prescribed medical practitioner (PMP) who has the appropriate training recognised by the General Practice Mental Health Standards Collaboration. GPs and PMPs who provide focussed psychological strategies services do so as part of an arrangement for the treatment of an assessed mental disorder under a MHTP.

The GP or PMP does not need to be the patient's usual medical practitioner or the patients GP or PMP at their MyMedicare registered practice.

How can an allied health professional check how many Better Access services are left on a patient's referral or if the referral comes from the usual medical practitioner or the patients MyMedicare practice?

Allied health professionals can call Services Australia on 132 150 to check on how many Better Access mental health treatment services have been claimed. Additionally, they can also access the Health Professional Online Services (HPOS) to view a patient's mental health treatment plan history.

If an allied health professional is unsure if their patient has a referral that has been undertaken by either a general practitioner or prescribed medical practitioner at the general practice the patient is enrolled in for MyMedicare, or the patient's usual medical practitioner, the allied health professional should contact the referring practitioner before undertaking the service.

Does the allied health professional need to provide a written report to the referring practitioner after a course of treatment?

Yes. Allied health professionals must provide a written report to the referring practitioner on the completion of any course of treatment.

The report informs the referring practitioner on the patient's progress and the treatments provided and allows the referring practitioner to determine if additional services are required.

Further information on what is required from allied health professionals on the completion of a course of treatment is outlined in explanatory notes MN.6.2 and MN.7.4 on MBS Online.

How do Mental Health Treatment Plans integrate with Chronic Condition Management Plans and Eating Disorder Treatment Plans?

Can a general practitioner (GP) or prescribed medical practitioner (PMP) provide a Chronic Condition Management Plan to a patient who already has a Mental Health Treatment Plan for the same condition?

Yes. There is nothing precluding a patient from having both a Chronic Condition Management Plan (CCMP) and a Mental Health Treatment Plan (MHTP), provided they meet the relevant eligibility requirements for each plan. Patient eligibility for each plan remains at the clinical discretion of the relevant general practitioner (GP) or prescribed medical practitioner (PMP).

If eligible for both plans, under the CCMP a patient can access 5 individual psychology services (Aboriginal and Torres Strait Islander patients may access up to 10 allied health services per year). This is in addition to the yearly cap of 10 individual and 10 group therapy mental health treatment services provided under a MHTP. GPs and PMPs should clearly document which plan is in place and monitor service usage to stay within Medicare Benefit Schedule limits.

It must be noted that eligibility requirements differ between both plans. Patients are eligible for a CCMP if they have at least one medical condition that has been (or is likely to be) present for at least 6 months or is terminal; and there is no list of eligible conditions. However, to be eligible to receive services under Better Access, people must have a clinically diagnosed mental disorder as defined by the World Health Organisation ICD-10 classification, which do not include dementia, delirium, tobacco use disorder and mental retardation.

Further information on CCMPs can be found in MBS Online - Note AN.0.47.

Can a general practitioner (GP) provide an Eating Disorder Treatment Management Plan to an eligible patient who already has a Mental Health Treatment Plan?

Yes. A general practitioner (GP) can provide an Eating Disorder Treatment and Management Plan (EDTMP) to a patient who already has a Mental Health Treatment Plan (MHTP), and vice versa, if they meet the clinical criteria for both plans. Each plan is assessed separately, therefore having a MHTP does not prevent a patient from accessing an EDTMP. If a patient has both a MHTP and an EDTMP, the services they can access depends on how many services remain on their EDTMP as follows:

- once the EDTMP commences, any services that are claimed under a MHTP will be counted towards the psychology services cap associated with their EDTMP
- under an EDTMP, a patient can access up to 40 evidence-based eating disorder psychological treatment services in a 12-month period
- having both plans does not increase the total number of services a patient can claim
- patients are not allowed more than 40 psychological treatment services within a 12-month period under the EDTMP
- any Better Access mental health treatment services provided before the EDTMP has commenced do not count towards the cap associated with the EDTMP, however, any that are provided after the EDTMP has commenced do count, as long as the patient still has a MHTP, valid referral and review requirements in place.

Further information on EDTMPs including its interaction with CCMP and Better Access services can be found in explanatory note AN.36.2 on MBS Online.

Medicare benefits for Better Access services

Will patients receive a Medicare benefit for Better Access psychological services?

Medicare benefits will only be paid for Better Access services if an eligible patient has a valid referral for mental health treatment services. The referral must have been undertaken by either a general practitioner (GP) or prescribed medical practitioner (PMP) at the general practice they are enrolled in for MyMedicare, or their usual medical practitioner. This includes a GP or PMP who is located at the medical practice that has provided the majority of a patient's care over the previous 12 months or will be providing the majority of the patient's care over the next 12 months. This restriction does not apply to:

- patients referred via a psychiatrist assessment and management plan (PAMP) by a psychiatrist, or
- by a direct referral from an eligible psychiatrist or eligible paediatrician, or
- mental health case conferencing Medicare Benefit Schedule (MBS) items.

All referrals must be valid to receive a Medicare benefit. Further information is available in explanatory note AN.0.78 which provides an overview of the Better Access initiative on MBS Online.

Can a patient receive a Medicare benefit for Better Access services whilst they are overseas?

No. Medicare benefits are payable for professional services provided only in Australia. Medicare does not cover medical expenses incurred outside of Australia. This includes telehealth services where the patient is in Australia, and the health practitioner is outside Australia and vice versa. The Health Insurance Act 1973 does not provide any discretion or exemptions to the requirement that Medicare eligible services need to be provided in Australia.

Nothing prevents a health professional providing telehealth services for patients whilst they are overseas, however, it does prevent them and the health professional from being able to claim a Medicare benefit for the service.

Do patients have to pay out-of-pocket costs for Better Access services?

An out-of-pocket cost is the difference between the amount the treating practitioner charges for a service and the amount Medicare or a private health insurer pays. This is also known as a 'gap' or 'patient payment'.

Under Medicare, general practitioners (GPs), prescribed medical practitioners (PMPs), specialists and allied health professionals are free to determine their own fees and bulk billing arrangements and are under no obligation to charge the Medicare Benefits Schedule fee set by Government, or to bulk bill. Payment of fees exceeding the Medicare benefit for Better Access services are the responsibility of the patient.

A patient must decide if they will use Medicare or their private health insurance ancillary cover (if applicable) to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare benefit paid for the services. If a patient has exhausted their Better Access mental health treatment services and has appropriate private health insurance ancillary cover for psychological services, they can choose to claim from their private health fund. Benefits payable to members with appropriate private health insurance cover will vary based on their level of ancillary cover.

Patients can find details of GPs, PMPs, psychiatrists, paediatricians, and other mental health professionals, including those that bulk bill and/or offer telehealth or telephone consultations at www.healthdirect.gov.au or Find a psychiatrist | Your Health in Mind.

Do Medicare Benefit Schedule items under the Better Access initiative attract bulk billing incentives?

Yes, MBS bulk billing incentives can be claimed when a Better Access service, such as a mental health treatment plan or focussed psychological strategies (FPS) services, is bulk billed.

The appropriate MBS bulk billing incentive can also be claimed when an attendance item (eg item 36) is used to review a mental health treatment plan or provide a mental health consultation, and the service is bulk billed.

As of 1 November 2025, all Medicare-eligible patients are eligible for bulk billing incentives. For practices participating in Bulk Billing Practice Incentive Program (BBPIP) mental health treatment plans, GP FPS and consultations are also eligible services for the purpose of the BBPIP.

Further information on bulk billing incentives is available in Note MN.1.1 to Note MN.1.8 [1.3-1.8 are MM-specific claiming tables] on MBS Online. The list of eligible services for the purpose of BBPIP is available here.

Better Access Telehealth (video and phone) Services

Can a person access individual mental health treatment services via telehealth (video and phone)?

If an eligible person with a clinically diagnosed mental disorder is accessing individual Better Access mental health treatment services via their eligible general practitioner (GP) or eligible prescribed medical practitioner (PMP) or their eligible allied health professional, they may be able to substitute their individual Better Access face-to-face services via telehealth (video and phone).

Patients are encouraged to speak with their GP or PMP or their eligible allied health professional to discuss the potential availability and suitability of Better Access services via telehealth (video or phone).

Further information on telehealth services can be found in the Better Access Telehealth frequently asked questions section on the Australian Government Department of Health, Disability and Ageing website.

Can a patient access group therapy mental health services from their current Better Access provider via telehealth (video)?

If an eligible person is accessing Better Access mental health treatment services through an eligible allied health professional, they may be able to substitute face-to-face consultations with their preferred provider through group therapy services via telehealth (video), where it is clinically appropriate and safe to do so, provided that:

- the patient resides in a telehealth eligible area (MMM 4-7 locations) and is located at least 15 kilometres (measured by the most direct route by road*) from the eligible health professional, and
- the health professional meets the relevant Medicare Benefit Schedule (MBS) registration requirements, and
- the provider agrees for this to occur.

*The eligible patient or eligible allied health professional is not permitted to travel to an area outside the minimum 15-kilometre distance to claim a video MBS item when using these items.

Further information on telehealth services can be found in the Better Access Telehealth frequently asked questions section on the Australian Government Department of Health, Disability and Ageing website.

What is the Modified Monash Model (MMM) 4-7 and how can patient's check their MMM classification to determine eligibility for Better Access Telehealth services?

Better Access uses the Modified Monash Model 4-7 categories to determine eligibility for telehealth (video) services for group therapy mental health treatment services, aiming to improve access for people in rural and remote areas by allowing these patients to receive all 10 video group therapy mental health treatment services under their MHTP. The MMM classifies areas based on population size and remoteness, with MMM 4-7 representing rural, remote, and very remote locations where there are often greater barriers to in-person healthcare services.

Patients can find further information about the Modified Monash Model, including a search tool to identify the classification of a specific location in the Modified Monash Model section on the Australian Government Department of Health, Disability and Ageing website.

What is an established clinical relationship?

It is a legislative requirement that general practitioners (GPs) and prescribed medical practitioners (PMPs) can only provide telehealth services for new Mental Health Treatment Plans (MHTPs) if they are the patient's MyMedicare registered practice or usual medical practitioner and have an established clinical relationship with the patient.

This means the patient must have had at least one face-to-face visit in the past 12 months with their GP or their PMP at their usual medical practice, or meet an specific exemption category (for example, patients who are homeless, affected by natural disaster or where the patient is receiving the services from a medical practitioner located at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service, or a person isolating because of a COVID-related State or Territory public health order or is receiving the services from a GP or PMP at their MyMedicare-registered practice. See Scenario 1.

More information on telehealth requirements is available at MBS Telehealth Services on MBS Online.

Further information on Better Access telehealth services can be found in the Better Access Telehealth frequently asked questions section in the Better Access Initiative resource collection.

Scenario 1

Lenny recently moved interstate and is experiencing mental ill health. He searches the internet for a nearby medical practice and asks for a telehealth appointment as he wants to stay at home instead of travelling to the practice.

The practice tells Lenny that, as he is a new patient and does not have an established clinical relationship with a GP or PMP at the practice, his first appointment must be a face-to-face consultation.

After his face-to-face consultation with a GP at the practice Lenny and the GP now have a established clinical relationship. Three months later, Lenny's mental health needs have changed, and he asks the GP for a telehealth consultation to discuss other treatment options. The GP can use their discretion to determine if a telehealth appointment is clinically appropriate, or if a face-to-face consultation is required.

Usual medical practitioner and MyMedicare

Usual medical practitioner

What does a usual medical practitioner mean?

A patients usual medical practitioner means a medical practitioner working in general practice who has provided the majority of care to the patient over the previous 12 months or will be providing the majority of medical practitioner services to the patient over the next 12 months. This also includes a general practitioner (GP) or prescribed medical practitioner (PMP) who is located at a medical practice that has provided the majority of their care over the previous 12 months or will be providing the majority of their care over the next 12 months.

Formalising the relationship between a patient, their general practice and GP or PMP will support continuity of care and ensure Better Access referrals are undertaken by practitioners who are familiar with the patient's medical history and mental health treatment needs.

What if a patient does not have a usual medical practitioner?

Patients without a regular medical practitioner may attend a general practice where a general practitioner or prescribed medical practitioner will deliver the majority of their mental health care over the next 12 months.

A patient can also nominate and register at a MyMedicare practice. Visit the MyMedicare website to obtain further information on how to register as a MyMedicare patient.

What if my usual medical practitioner is on holiday or leaves the medical practice?

A patient is able to see another general practitioner (GP) or prescribed medical practitioner (PMP) who is located at their usual medical practice that has provided the majority of a patient's care over the previous 12 months or will be providing the majority of their care over the next 12 months to receive a new mental health treatment plan (MHTP), referral or review of their MHTP in order to be eligible for the Better Access initiative MBS items.

What if a patient has a medical practitioner for their physical needs and a different medical practitioner for their mental health needs?

It is recognised that patients may choose to have a separate general practitioner (GP) or prescribed medical practitioner (PMP) for mental health support. Where a patient receives consistent care from more than one GP or PMP, the 'usual medical practitioner' definition will still apply for the relevant medical practitioner who has been providing the majority of mental health care services to the patient over the previous 12 months or will be providing the majority of mental health care services to the patient over the next 12 months.

See Scenario 2.

Scenario 2

Maggie is not registered for MyMedicare but regularly visits 2 different general practices for unrelated health issues. She sees her long-standing GP at Practice A for her ongoing mental health condition, but when she has the flu and needs a medical certificate for work, she visits Practice B, which is closer to her office.

From 1 November 2025, Maggie will still be able to access MHTP preparation, review and referral services at Practice A as long as this service is provided by her usual medical practitioner.

Maggie can continue to visit Practice B for consultations not directly related to the management of her mental health condition for other services such as medical certificates, scripts or a referral for blood tests, without the usual medical practitioner requirement.

MyMedicare

What is MyMedicare?

MyMedicare is a voluntary patient registration program introduced to strengthen the relationship between patients and their regular general practice, general practitioner and prescribed medical practitioner, and primary care team.

Where can patients, general practices and healthcare providers find more information about MyMedicare?

Patients can find further information about MyMedicare, including eligibility requirements and exemptions at Patient information for MyMedicare.

Information on the requirements for MyMedicare general practices and healthcare providers can be found here: General practices and healthcare providers MyMedicare information.

What if a patient is not registered with MyMedicare?

A patient will not be disadvantaged if they do not register for MyMedicare as they can use the usual medical practitioner option for Better Access services.

This means a patient can choose to see their usual medical practitioner irrespective of their existing MyMedicare registered status. This includes any general practitioner or prescribed medical practitioner who is located at the medical practice that has provided the majority of a patient's care over the previous 12 months or will be providing the majority of a patient's care over the next 12 months. This provides flexibility for patient choice and enables patients to structure their physical and mental health care requirements in line with their personal preference and circumstances.

Can a patient be registered under MyMedicare but see a different general practitioner (GP) or prescribed medical practitioner (PMP) (usual medical practitioner) for their mental health care and still receive a Medicare benefit under Better Access?

Yes. Importantly, patients can choose to see their usual medical practitioner irrespective of their existing MyMedicare registered status. This enables people to structure their physical and mental health care requirements in line with personal preference, which can commonly look like seeing a different medical practitioner for mental health support needs for a wide variety of reasons. Patient's will continue to have discretion to determine their usual medical practitioner for the purposes of their mental health support needs.

For example, if a patient is registered with a MyMedicare practice but wishes to see a general practitioner (GP) or prescribed medical practitioner (PMP) at another practice as they consider them to be their 'usual medical practitioner' for their mental health support needs, there is nothing precluding the patient from doing so because of the changes coming in to effect under Better Access from 1 November 2025.

Can a patient follow their general practitioner (GP) or prescribed medical practitioner (PMP) to another MyMedicare registered practice?

Yes. A patient can also change their MyMedicare registration details to follow their general practitioner (GP) or prescribed medical practitioner (PMP) as long as the practice they are moving to

is registered with MyMedicare. In this scenario, the patient will not need to meet minimum MyMedicare eligibility requirements at the new practice as their existing relationship with their GP or PMP will be recognised.

Further information on exemptions and eligibility requirements is located on the MyMedicare website.

Can a patient change their MyMedicare practice?

If a patient wants to register with a different practice, they can do so if they meet the eligibility requirements and the new practice is registered with MyMedicare. When a patient registers at a new practice, their previous registration is automatically withdrawn, and the former practice is notified of this change.

Where a patient changes their general practitioner (GP) or prescribed medical practitioner (PMP) and the new GP or PMP is not part of the patient's registered MyMedicare practice, they will continue to be eligible for mental health treatment services provided the MyMedicare requirements and the minimum visit eligibility requirements are met.

Further information for MyMedicare patients including eligibility requirements is available on the MyMedicare website.

What if my general practitioner (GP) or prescribed medical practitioner (PMP) at my MyMedicare registered practice is on holiday or leaves the medical practice?

A patient is able to see another general practitioner (GP) or prescribed medical practitioner (PMP) at the general practice they are enrolled in for MyMedicare to receive a new mental health treatment plan (MHTP), referral or review in order to be eligible for the Better Access initiative MBS items.

A patient can also change their MyMedicare registration details to follow their GP or PMP as long as the practice they are moving to is registered with MyMedicare. In this scenario, the patient will not need to meet minimum MyMedicare eligibility requirements at the new practice as their existing relationship with their GP or PMP will be recognised.

Further information on exemptions and eligibility requirements is located on the MyMedicare website.

How does a medical practice know if a patient has changed their MyMedicare practice registration?

If a patient changes the MyMedicare practice they are registered with, the MyMedicare system will automatically cancel their registration with their previous practice. The system will let the previous practice know that the patient has cancelled their registration. Further information is available at MyMedicare | Australian Government Department of Health, Disability and Ageing.

Will registering a MyMedicare practice lock a patient into a specific location?

No. MyMedicare registration will not prevent a patient from accessing care from other practices and healthcare providers for services that are not specifically linked to MyMedicare. For example, if a patient is travelling interstate and needs to see a general practitioner (GP) or prescribed medical

practitioner (PMP), they can still access a different GP or PMP for various treatment services, however MyMedicare incentives are only available at the patient's MyMedicare registered practice.

Patients may be able to substitute their individual Better Access face-to-face service with a telehealth (video and phone) service however, eligibility requirements and exemptions may apply. To be eligible for telehealth (video) services for the preparation of a Mental Health Treatment Plan under Better Access, patients must receive this services from a GP or PMP at their MyMedicare registered practice or their usual medical practitioner and have had at least 1 face-to-face appointment in the previous 12 months with a GP or PMP or meet any of the other exemptions to the established clinical relationship rule. Further information on telehealth requirements and exemptions is available at MBS Telehealth Services on MBS Online.