



Australian Government

Department of Health,
Disability and Ageing

Notification of bank account details for a hospital authority

Purpose of this form

If you are acting on behalf of a hospital authority approved under section 94 of the *National Health Act 1953* (Act), complete this form to update or provide banking details to the Australian Government Department of Health, Disability and Ageing (department) for payments made through claiming for the Pharmaceutical Benefits Scheme.

You will need to allow **10 working days** for the change to take effect.

Payments for PBS claims can only be paid to the approved hospital authority's bank account.

For more information

Go to www.health.gov.au/pbsapprovedsuppliers.
For assistance completing this form, email details of your enquiry to pbsapprovedsuppliers@health.gov.au.

Returning your form

Check that all required questions are answered and the form is signed and dated.

This form, and any related attachments, must be lodged via the PBS Approved Suppliers Portal (Portal)

PBSApprovedSuppliers.health.gov.au by a registered and signed in Portal user.

Further information on how to lodge your form is available at www.health.gov.au/pbsapprovedsuppliers under Guides and Forms – *How to upload PDF forms or additional requested information*.

Please do **not** email your form as emailed forms will not be processed.

Privacy and your personal information

Personal information is protected by law, including the *Privacy Act 1988*.

Personal information is being collected in this form by the department for the purposes of processing your notification of an approved hospital authority's new bank account details or changes to existing bank account details for the purposes of claiming for the Pharmaceutical Benefits Scheme.

If you do not provide this information, the department will not be able to process your notification.

You can get more information about the way in which the department will manage personal information, including our privacy policy, at www.health.gov.au/using-our-websites/website-privacy-policy/privacy-notice-for-the-pbs-approved-suppliers-portal.

Hospital authority and hospital details

'Hospital authority' means the governing body of a public hospital or the proprietor of a private hospital.

This **is not** the name of the hospital.

The details in this section must be consistent with the details recorded by the department for the PBS approval number provided at question 2.

1 Hospital authority name

2 PBS approval number

3 Hospital name

4 Hospital address

Postcode

5 Hospital switchboard phone number

Contact person's details

This is the person authorised to discuss details on this form.

6 Dr Mr Ms Other

Family name

First given name

7 Position held

8 Daytime phone number

Mobile phone number

Email

Hospital authority bank account details

Processing of forms takes up to 10 business days, therefore requests to register new bank account details or change bank account details should be submitted at least 10 business days prior to the date nominated at question 11 below.

- 9** I would like to: **Tick ONE only**
- Register new bank account details **Go to 11**
- Change existing bank account details **Go to next question**

- 10** If notifying the department of a change to bank account details, record the existing bank account details below.

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

- 11** The following account details are to be used, effective from

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

All payments are made through Electronic Funds Transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT deposits.

Declaration

12 I authorise:

- payments to be made into the bank account of the approved hospital authority named at question 1.

I declare that:

- I am authorised to provide these details on behalf of the hospital authority named at question 1 in respect of the hospital named at question 3.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Name

Signature

Date

Position held

Contact phone number