

Assignment of Benefit for Simplified Billing Services

March/April 2026



Assignment of Medicare Benefits (AOB) – what is it?

The process for a patient to have their Medicare benefit paid to someone else.

For in-patient medical claims, this is usually to a private health insurer or an approved billing agent.

The *Health Insurance Act 1973* sets out the legal requirements for this process.

Simplified billing assignment pathways

Pathway	Context	Key Message	Who is making the claim		Private Health Insurer or Billing Agent
			Health professional	Hospital/Organisation	
Implied Assignment	An insurer arrangement applies to the service (e.g., gap cover agreements or MPPAs, etc.).	An automatic assignment of the Medicare benefit to a private health insurer or approved billing agent. No explicit patient signature or request is required.	<ul style="list-style-type: none"> • Complete the claims declaration when submitting a claim • Retain records relevant to the assignment 	<ul style="list-style-type: none"> • Complete the claims declaration when submitting a claim • Retain records relevant to the assignment 	
Requested Assignment	An insurer arrangement does <u>not</u> apply to the service (e.g., contracts relating to hospital accommodation, theatre fees, etc. but not medical services).	A manual assignment request by the patient (assignor). Facilitated by the medical provider, hospital, or organisation. Can occur before or after the service (ideally before as part of IFC). Can be conducted digitally or in any written format.	<ul style="list-style-type: none"> • Health professional needs to facilitate the assignor's request to assign the Medicare benefit to the insurer or billing agent • Give the assignor a copy of the assignment (if requested) • Obtain assignor's written approval if assignment needs to be modified • Complete the claims declaration when submitting a claim • Retain relevant records 	<ul style="list-style-type: none"> • Hospital/organisation needs to facilitate the assignor's request to assign the Medicare benefit to the insurer or billing agent • Give the assignor a copy of the assignment (if requested) • Obtain assignor's written approval if assignment needs to be modified • Complete the claims declaration when submitting a claim • Retain relevant records 	<ul style="list-style-type: none"> • Notify the assignor and/or patient within 6 months of receiving the Medicare benefit • Retain relevant records



*Blue text is anticipated change to current processes.

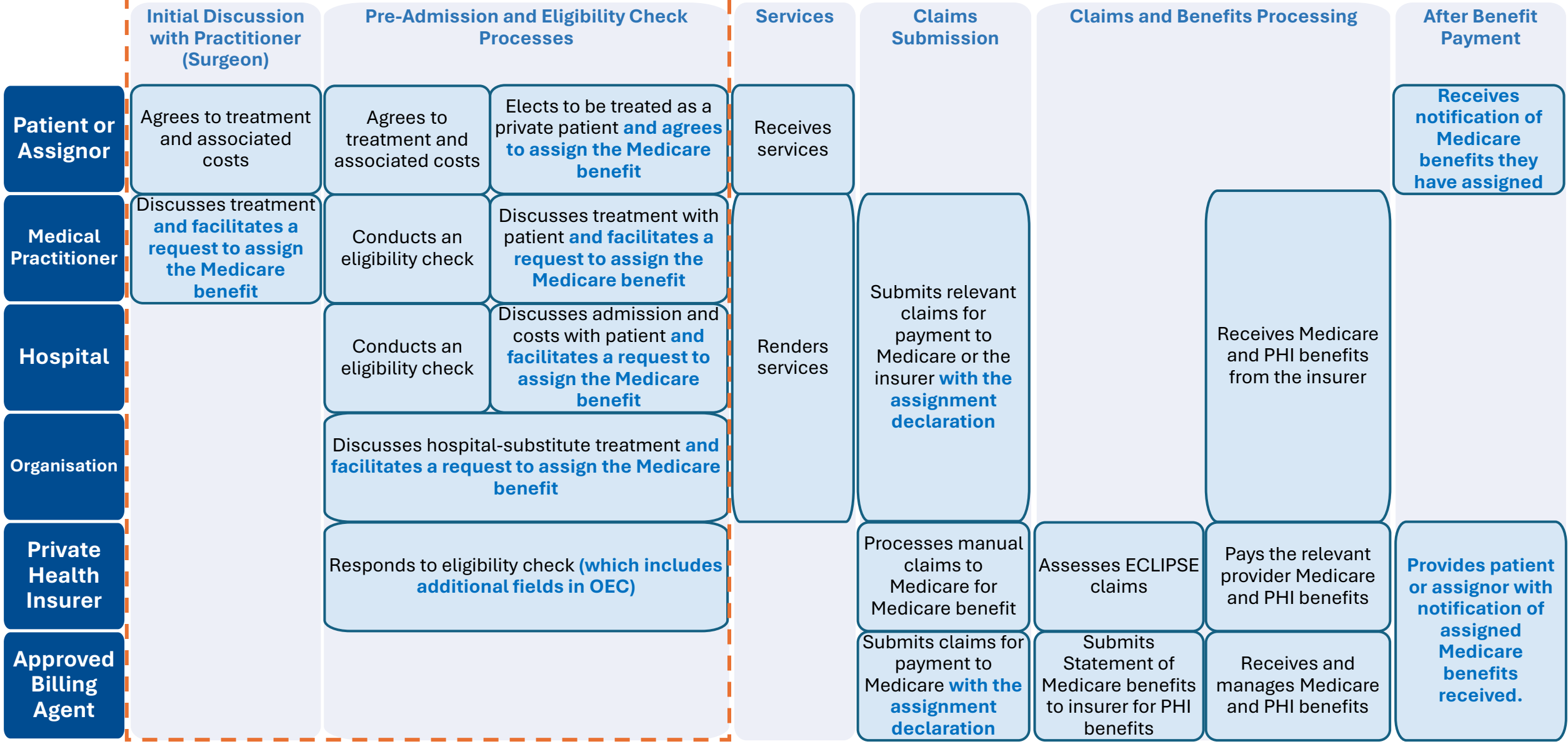
Informed Financial Consent Process

	Initial Discussion with Practitioner (Surgeon)	Pre-Admission and Eligibility Check Processes		Services	Claims Submission	Claims and Benefits Processing		After Benefit Payment
Patient or Assignor	Agrees to treatment and costs	Agrees to treatment and associated costs	Elects to be treated as a private patient	Receives services				Receives notification of Medicare benefits they have assigned
Medical Practitioner	Discusses treatment and decides to use a gap cover arrangement	Conducts an eligibility check	Discusses treatment and decides to use an insurer arrangement (gap cover, MPPA, etc.)	Renders services	Submits relevant claims for payment to Medicare or the insurer with the assignment declaration		Receives Medicare and PHI benefits from the insurer	
Hospital		Conducts an eligibility check	Discusses admission and costs with patient					
Organisation		Discusses hospital-substitute treatment and an insurer arrangement applies to the service.						
Private Health Insurer		Responds to eligibility check (which includes additional fields in OEC)			Processes manual claims to Medicare for Medicare benefit	Assesses ECLIPSE claims	Pays the relevant provider Medicare and PHI benefits	Provides patient or assignor with notification of assigned Medicare benefits received.
Approved Billing Agent					Submits claims for payment to Medicare with the assignment declaration	Submits Statement of Medicare benefits to insurer for PHI benefits	Receives and manages Medicare and PHI benefits	

Implied Assignment Process

*Blue text is anticipated change to current processes.

Informed Financial Consent Process



Requested Assignment Process

Information provided to assignor – Requested assignment

Information	Request facilitated by operator of hospital (Hospital treatment)	Request facilitated by an organisation (Hospital-substitute treatment)	Request facilitated by a health professional (Hospital-substitute treatment)
Patient's name	Patient's name		
Patient's PHI details	Name of patient's private health insurer, and the patient's membership number or PHI identifier		
Who is the request being made to	Name of operator of hospital	Name of organisation	Name of health professional
Date	Date of admission or date of service		
Health professional/s covered by the assignment request	Either: list of health professionals covered by the assignment OR a statement that the assignment covers all health professionals authorised by the hospital operator to provide treatment to the patient	Either: list of health professionals covered by the assignment OR a statement that the assignment covers all health professionals authorised by the organisation to provide treatment to the patient	Name of health professional
Description of hospital/hospital-substitute treatment	Description of hospital treatment	Description of hospital-substitute treatment	Description of hospital-substitute treatment
Who the benefit/s are assigned to	Name of private health insurer OR approved billing agent		
Location where service/s are rendered	Name of hospital, address, OR a statement that it is rendered in a private residence	Address OR a statement that it is rendered in a private residence	Address OR a statement that it is rendered in a private residence



Information provided to assignor – Requested assignment

Requested assignment wording:

I assign my right to Medicare benefits to [*name of private health insurer / approved billing agent to whom the benefit/s are to be assigned to*] in respect of any professional services provided [*to me / to name of patient*] as part of hospital treatment relating to [*description of condition/treatment/services*] and including any associated pathology, diagnostic imaging and referred professional services (*if applicable*) provided by or on behalf of [*health service professionals or refer to list of names of health professional/s*] authorised by [*name of responsible provider*] at [*location where the professional service will be/was rendered*] [*during my / name of patient's*] admission commencing [*date of admission*].

Hospital treatment description example for a cardiac-related admission:

“the investigation and treatment of heart, heart-related conditions and vascular system, including any associated pathology, diagnostic imaging and referred professional services”

More info at : [Health Insurance Amendment \(Assignment of Medicare Benefits and Other Measures\) Regulations 2025 Explanatory Statement](#)



Australian Government

Department of Health, Disability and Ageing

Changes to Online Eligibility Check Web Services (OEC)

- There are two new fields for the insurer response: Product Tier and Additional Clinical Categories.
- For all Plus PHI products, the insurer will be required to include any optional clinical categories covered in addition to the mandatory clinical categories.

Sample of OEC insurer response for a Silver Plus product:

- healthFundTable: ...
- tableDescription:
- tableName: “Silver Plus Family 100”
- tableScale: “Couple”
- **ProductTier:** SilverPlus
- **Additional Clinical Categories:** Cataracts, Joint replacements, Dialysis for chronic kidney failure, Pregnancy and birth, Assisted reproductive services

Changes to simplified billing claims

Sample of a manual invoice with the claims declaration:

Medical Gap Cover Claim

Invoice #310326

Provider: Dr Medicare

Provider number: 1234567AB

Date of Service	MBS Item	Fee
26/03/2026	32222	\$390.05
26/03/2026	32229	\$157.30

This claim for Medicare benefits has been assigned under implied assignment.

- If the Medicare benefit is to be paid to an insurer or approved billing agent first, claims declaration is required (ECLIPSE and manual claims).
- This is the responsibility of the person making the claim (either the hospital, health professional, organization, or approved billing agent).

Which declaration?	Implied Assignment	Requested Assignment
Insurer arrangement applies (e.g., Gap Cover, MPPA, etc.)	✓	
Insurer arrangement does not apply (e.g., doctor has Gap Cover but is not using it for the service, doctor does not have an insurer arrangement)		✓
Insurer arrangement applies but doctor is also covered by a requested assignment through the hospital	✓	

Questions

Relevant Links:

- [*Health Insurance Legislation Amendment \(Assignment of Medicare Benefits\) Act 2024*](#)
- [*Health Legislation Amendment \(Miscellaneous Measures No. 1\) Act 2025*](#)
- [*Health Insurance Amendment \(Assignment of Medicare Benefits and Other Measures\) Regulations 2025*](#)
- [Consultation on Assignment of Medicare Benefits for Simplified Billing Services](#)
- [Modernising the ‘Assignment of Benefit’ process for Medicare bulk billed services and simplified billing services](#)
- [Improving the Assignment of Benefit Process](#)

