Australian Government
Department of Health, Disability and Ageing

Assignment of Medicare Benefits for Bulk Billing

Frequently Asked Questions

as at 26 June 2026

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Background

- Under the *Health Insurance Act 1973* (the Act), the Australian Government subsidises the cost of health services. This is the legal basis for Medicare benefits to be paid to patients. When patients direct their Medicare benefit payment to their healthcare provider as full payment for a bulk-billed service, this requires an 'assignment of benefit' (AoB). In assigning their benefit, a patient is required to sign an agreement.
- During the COVID-19 pandemic, the Department of Health, Disability and Ageing (the department) issued temporary guidelines to support the AoB process for telehealth services. Under the temporary arrangements in certain situations, patients could verbally consent, as opposed to signing an agreement, to assign a benefit following their consultation with their doctor.
- In January 2023, the Australian National Audit Office released a report which noted that there could be legal risks with undertaking the AoB process verbally, without the requirement for the patient to sign. The Minister for Health, Disability and Ageing responded by asking the department to modernise the process of assigning benefits which will make it easier, safer, and more efficient for everyone.
- The Government has pursued legislative reforms to enable this for bulk billing and simplified billing of privately insured hospital and hospital-substitute treatment.
- Updated AoB requirements commence on 1 July 2026. From this date, claiming forms from Services Australia will be updated to meet the requirements. This includes the DB4e and DB020 forms on the Services Australia website, and other DB manual claiming forms which will be available for stationery orders.
- An assignment of benefit agreement will need to contain the required information as per subsection 65C(4) of the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.
- AoB requirements outlined in this factsheet do not apply to patients accessing health care funded by the Department of Veterans' Affairs or under the Child Dental Benefits Scheme.

What are the changes?

The Australian Government has not made any new laws introducing signature requirements for patients to access bulk billing under Medicare. It has been a longstanding requirement under the Act that for bulk billing to occur, a patient (or another person on behalf of a patient as appropriate) must assign their Medicare benefit to the provider in exchange for not incurring any out-of-pocket costs.

When the amendments commence on 1 July 2026:

- Patients will be able to assign a benefit before (episodic pre-service assignment) or after a service (episodic post-service assignment) is received, so long as patient agreement is made prior to an MBS claim being lodged.
- Enduring assignment of benefit is an option for eligible patients registered with MyMedicare, residents of aged care homes, and patients of Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMS).
- Practitioners, billing agents, and private health insurers will no longer need to use an 'approved form', so long as agreements include the information required for each type of episodic agreement, as set out in subsection 65C(4) and subsection 65D of the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025 (the 'data set').
- Practitioners will no longer need to sign the agreement.
- An electronic or physical signature will be required from the patient or responsible person on an AoB agreement. A signature must be identifiable, auditable, and compliant with the *Electronic Transaction Act 1999*.
- Practitioners will be required to keep a copy of the completed AoB agreements for two years and must provide a copy to the patient upon request.

Why are the changes being made?

In January 2023, the Australian National Audit Office released a report titled Expansion of Medicare Telehealth Services. The report found that there could be legal risks with assigning benefits verbally. The Minister for Health, Disability and Ageing responded by asking the department to modernise the process of assigning benefits for all bulk billed Medicare services.

The following legislative reforms have been pursued to modernise and simplify AoB processes for bulk billing and simplified billing:

- The *Health Insurance Amendment (Assignment of Medicare Benefits) Act 2024* passed Parliament on 2 July 2024 and received Royal Assent on 9 July 2024.
- The *Health Legislation Amendment (Miscellaneous Measures No. 1) Bill 2025* passed Parliament on 30 October 2025 and received Royal Assent on 4 November 2025 for implementation on 1 July 2026.

These are supported by amendments to the Health Insurance Regulation 2018 as follows:

- On 21 August 2025, the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025 was made by the Governor-General at a meeting of the Executive Council (ExCo).
- On 28 May 2026, the Health Insurance Amendment (Episodic Agreements and Simplified Billing Assignments) Regulations 2026 was made by the Governor-General at a meeting of the Executive Council (ExCo).
- On 25 June 2026, the Health Insurance Amendment (Enduring Agreements) Regulations 2026 by the Governor-General at a meeting of the Executive Council (ExCo).

Where can I find more information?

For more information on the process of improving the assignment of benefit, please refer to: Improving the assignment of benefit process - Australian Government Department of Health, Disability and Ageing.

For enquiries or further details regarding the Assignment of Benefit (AoB) project, please reach out to: AssignmentofBenefit@health.gov.au

Frequently asked questions

What is the government doing to support the transition to the new assignment of benefit requirements after 1 July 2026?

The Australian Government and Department of Health, Disability and Ageing have listened to concerns raised by stakeholders about the amended Medicare assignment of benefit legislative requirements that will take effect on 1 July 2026. While there will be greater flexibility in how health providers can obtain patient consent for bulk billed services, the department recognises this is a significant change for many.

In response, regulatory amendments will be made to support a 12-month transition period. This includes enabling verbal assignment of benefit for all bulk billed patients, in all settings. These regulatory amendments are being progressed as a priority. The Department will also use the 12-month transition period to explore other regulatory and legislative options to further reduce the administrative burden on both GP practices and patients while ensuring the integrity of Medicare is maintained.

Providers and software vendors that have already prepared or are preparing for the new arrangements, including through digital solutions, should continue that work. The department recognises the substantial efforts by those who are working towards implementation.

In addition, regulatory amendments have been progressed that would reduce administrative burden for bulk billing GP services through the introduction of an 'enduring' assignment of benefit option for eligible patients. This means that from 1 July 2026, patients registered with MyMedicare, residents of aged care homes, and patients of ACCHOs and AMSs will be able to make an enduring assignment of benefit for ongoing GP bulk billed services, either directly or through a person acting on their behalf.

- A patient registered with MyMedicare will be able to make one enduring agreement to receive services from all general practitioners at their MyMedicare practice, if offered.
- A patient of an ACCHO or AMS will be able to make an enduring agreement with the ACCHO or AMS, and they will be able to have multiple agreements with multiple ACCHs or AMS.
- A patient living in a residential aged care home will be able to make multiple enduring agreements with different practitioners.

It is important to note that none of these changes impact the new requirements for simplified billing arrangements. The legislative requirements that start from 1 July 2026 for privately insured services claimed as part of hospital and hospital substitute treatment will remain unchanged.

The department will continue to work with stakeholders regarding the changes outlined above. Once these regulatory changes are finalised, our compliance approach will be consistent with the department's health provider compliance strategy. The department will prioritise prevention and education as practitioners work towards adopting new assignment of benefit requirements – within a risk based approach to its' ongoing compliance efforts. We appreciate practitioners' ongoing dedication to compliance and welcome your suggestions and questions regarding these changes.

Can I use the DB4e or DB020 forms after 1 July 2026?

You will be able to use an updated DB4e or DB020 form from 1 July 2026, but you won't have to if you have an alternative solution.

Services Australia are updating DB forms. The updated DB4E and DB020 forms will made available from Services Australia website from 1 July 2026. Prior versions of 'approved forms' for assignment of Medicare benefits will no longer meet the requirements for a valid Assignment of Benefit (AoB) agreement.

All other DB forms will continue to be available through the existing stationery ordering process.

If you require specific information about which form should be used for particular claiming scenarios, please contact Services Australia

Under the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025, the concept of an 'approved form' is replaced with a mandatory information set (referred to as a *data set*) that must be provided to, and agreed by, the assignor.

Importantly, there is no prescribed template or mandatory form. An AoB agreement may be presented in any format (paper or electronic), provided it includes all the information required to be given to the assignor under the regulations and is agreed to in writing.

If all required information is present and the assignor has agreed, the document will constitute a valid record of assignment of Medicare benefit, regardless of its format.

A completed AoB agreement must be retained by the provider (electronically or in hard copy) for two years and may be requested as evidence for compliance or audit purposes.

What are the requirements for pre- and post- assignment?

The table below sets out a high-level summary of the information required for an episodic pre- and post-assignment agreement. Seven (7) points of information must be recorded for each assignment.

The provider must ensure all required fields are completed (except the section specifying if the assignor is the patient (yes/no). For example, if the patient is a child under 14, the parent would typically be the assignor.

The patient should be provided with a completed document (physically or electronically), and asked to sign it to confirm consent to assign their Medicare benefit to the healthcare provider.

For further clarification, refer to the requirements as worded in section 65C Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.

Assignment Type	Pathology (excluding Group 9)	Diagnostic Imaging	All other MBS services (including Group P9)
Pre-assignment	• Patient name • Date of assignment • Assignment type (pre-assignment) • Is the assignor the patient – yes/no • Date of specimen collection • Statement of assignor's agreement* • Description of the service	• Patient name • Date of assignment • Assignment type (pre-assignment) • Is the assignor the patient – yes/no • Date of imaging procedure • Statement of assignor's agreement (R type services)# • Description of the service	• Patient name • Date of assignment • Assignment type (pre-assignment) • Is the assignor the patient – yes/no • Details of the professional • Date of service • Basic service description
Post-assignment	• Patient name • Date of assignment • Assignment type (post-assignment) • Is the assignor the patient – yes/no • Date of specimen collection • Details of the professional (per Section 54 of the HIR) • MBS item/s	• Patient name • Date of assignment • Assignment type (post-assignment) • Is the assignor the patient – yes/no • Date of imaging procedure • Details of the professional • MBS item/s	• Patient name • Date of assignment • Assignment type (post-assignment) • Is the assignor the patient – yes/no • Details of the professional • Date of service • MBS item/s

* statement captures pathologist determinable services
# statement captures DI services as per Section 16B of the HIA (i.e. services deemed required by rendering professional

How will the department approach compliance during early implementation after 1 July 2026?

The department will continue to work with stakeholders regarding the assignment of benefit changes. Our compliance approach will be consistent with the department's health provider compliance strategy. The department will prioritise prevention and education as practitioners work towards adopting new assignment of benefit requirements – within a risk based approach to its' ongoing compliance efforts. We appreciate practitioners' ongoing dedication to compliance and welcome your suggestions and questions regarding these changes.

Do adults accompanying children have to be the parents or a legal guardian to be able to assign for a minor?

No. An assignment only needs to be made by the person, or 'assignor,' who would otherwise meet the cost of the medical service if it were not being bulk billed. While this often is a parent, guardian, or carer, it is not limited to these relationships. Persons employed by the medical practitioner rendering the medical service cannot be the 'assignor' as there is a perceived financial conflict of interest. If those persons are the parents or carers of the patient however, it would be considered acceptable for them to assign on the child's behalf.

Practices should consider that the person who makes the assignment is being presented with health-related information about a patient (i.e. the new 'data set' information). Protecting the patient's privacy is important and should be taken into account in all transactions.

For situations where a patient lacks capacity to make their own financial decisions, further information is available on Services Australia's website about acting for someone with Medicare.

What if the medical service ends up being different from what is booked?

If the medical service provided is different from what has been assigned under an episodic pre-service agreement, a new AoB agreement will need to be obtained which reflects the service rendered. If it is known that the service will be different to what has been booked before the service is provided, then a new pre-service agreement could be sought from the patient. Otherwise, a post-service episodic AoB agreement should be obtained from the patient.

The ‘data set’ required for a post-service AoB agreement is different to a pre-service AoB agreement. For all post-service agreements, the MBS item number/s must be recorded in the agreement.

Providers should consider whether the use of pre-service assignment is compatible with their workflow and operating environment. If service details vary frequently between booking and delivery, providers should consider if post-service episodic assignments are more suitable.

What if the service ends up being different from what was on the pre-assignment agreement?

Pre-assignment agreements are established by using a category of services that could be within scope. This is categorised through the ‘basic service description,’ which is intended to be more meaningful for assignors while allowing providers to update MBS items without requiring additional assignment agreements.

If the rendered service is inside the scope of the basic service description, then the agreement remains valid.

If the rendered service is outside the scope of the basic service description, then the agreement is no longer valid and a post-service assignment agreement with correct information is required.

Can patients provide their assignment verbally?

In response to concerns raised by stakeholders about the amended Medicare assignment of benefit legislative requirements, regulatory amendments will be made to support a 12-month transition period. This includes enabling verbal assignment of benefit for all bulk billed patients, in all settings.

Use of verbal assignment will not negate the requirement of completed agreements to be retained for 2 years for record-keeping purposes.

What are the transitional arrangements for pathology?

Where an AoB agreement exists on a request for pathology tests that was issued prior to 1 July 2026, it can still be used for up to 12 months from the date of issue.

For all other services, where an AoB agreement is required to support a manual claim, or a resubmitted claim made from 1 July 2026, for services rendered before 1 July 2026, the updated AoB agreement data set will be required to evidence an assignor's agreement.

What constitutes a ‘signature’/accepted assignment of benefit?

From 1 July 2026, providers will no longer be required to sign an agreement. Patients (or their assignor) will continue to be required to sign an agreement to evidence their consent to assign their Medicare benefit. A physical or electronic signature is acceptable.

Where an electronic signature is used, it must meet the requirements of the *Electronic Transactions Act 1999* Part 2, Division 2 Section 10. It must:

- reliably identify the assignor
- reliably indicate assignors' agreement (by requiring an action)
- meet all other privacy and information technology requirements.

In response to concerns raised by stakeholders about the amended Medicare assignment of benefit legislative requirements, regulatory amendments will be made to support a 12-month transition period. This includes enabling verbal assignment of benefit for all bulk billed patients, in all settings.

Use of verbal assignment will not negate the requirement of completed agreements to be retained for 2 years for record-keeping purposes.

What if new digital processes cannot be implemented by 1 July 2026?

From 1 July 2026, medical practitioners will be required to use updated AoB processes and agreements to secure a compliant assignment before related bulk-billed Medicare claims can be made. The changes under the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024* allow for digital options, but do not require them.

If digital solutions are not available from 1 July 2026, paper forms can still be used. Completed AoB agreements are required to be retained by the provider for two years, and a copy provided to the patient if requested. However, they **are not required** to be submitted to Services Australia, except for manual claims.

Templates for of AoB agreements will be available from the Services Australia's website. Alternatively, providers can develop their own agreement (e.g. create a Microsoft word document) based on the requirements outlined in the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.

Copies of completed AoB agreements may be required as evidence of a legally compliant bulk-billed service as part of compliance activities.

What if the patient does not agree to assign their Medicare benefit?

If the patient does not agree to assign their Medicare benefit, they should be privately billed and provided with an invoice to enable them to claim their Medicare benefit from Services Australia.

In a pre-assignment scenario, the patient may choose not to assign their Medicare benefits initially, opting instead to make this decision after services have been provided. If the patient ultimately declines to assign their Medicare benefits, they will be responsible for the out-of-pocket payment.

For unpaid and partially paid accounts, the patient may request that a cheque for the Medicare benefit is sent by Services Australia to the patient to send to the provider. Further information can be found on Services Australia's website 90 day pay doctor cheque scheme - Health professionals - Services Australia

Do general practitioners (GPs) need new pathology request forms, and what will happen to the existing ones?

Any pathology request forms issued to patients prior to 1 July 2026 will remain valid for AoB purposes for up to 12 months. However, any request issued to patients after that date must comply with the new AoB requirements.

If request forms are used which do not reflect the new assignment 'data set,' a patient's assignment could be obtained when they are at a collection centre to have a specimen taken. Options would be to amend the old form to include any missing information or use a new AoB agreement in hard or electronic copy. Similarly, if a specimen is collected in a practice by a GP, the required information could be added to an old request, or the receiving pathologist could seek a patient's post-service assignment agreement.

The information required for pathology (excluding group P9) assignment of benefit agreements from 1 July 2026 include the following:

Pre-assignment	**Post-assignment**
Patient Name	Patient Name
Date of assignment	Date of assignment
Assignment type (i.e. pre or post)	Assignment type (i.e. pre or post)
Is the assignor the patient – yes/no	Is the assignor the patient – yes/no
Date of specimen collection	Date of specimen collection
Statement of assignor's agreement for all services on the referral and to capture pathologist determinable services	Details of the professional (as per Section 54 of the *Health Insurance Regulations 2018*)
Description of the service	MBS item/s

A detailed outline of the requirements for the pathology AoB agreements can be found in the *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.*

Scenario 1 – Request form obtained prior to 1 July 2026 and used after the commencement date

Any pathology request forms obtained by a patient prior to 1 July 2026 will remain valid for AoB purposes for up to 12 months.

Scenario 2 - Request form obtained after 1 July 2026, using the old, printed request forms (notepads), and used after the commencement date

For scenarios where a hard-copy pathology request form from the printed notepad is obtained after the commencement of the new arrangements, the provider or collection centre must add the missing data sets at the point of specimen collection. In most cases this will be the addition of:

- Assignment type (pre- or post-)
- Is the assignor the patient? (yes/no)

In some cases, the following data sets will also need to be added:

- Details of the professional (as per Section 54 of the *Health Insurance Regulations 2018*)
- MBS item/s

Scenario 3 – Request form obtained after 1 July 2026 and used after the commencement date

Any requests issued after the commencement date must comply with the new AoB requirements. If the provider chooses to separate the AoB agreement from the request, the agreement must also comply with the new requirements.

The AoB agreement, whether embedded on or separate from the request, can be completed electronically or via hard copy.

Will basic service description groups be included in the MBS XML for easier loading?

The XML fee file which software providers are familiar with will not contain the basic service description classifications for pre-assignment agreements.

However, the 'Health Insurance Regulations 2018 - Basic Service Description for Assignment of Medicare Benefit' document will be uploaded to the downloads section on MBS Online, where providers are accustomed to finding the XML fee file (https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads).

The document will be available as an XML and CSV.

The Basic Service Description will be updated quarterly in line with regular updates to the XML fee file (being 1 January, 1 July, 1 March, and 1 November).

How does episodic pre-service assignment function?

From 1 July 2026, patients can be offered the option to assign their Medicare benefits in return for being bulk billed (and face no out-of-pocket costs) before their appointment. This could be done when patients check in for their appointment, when they book a service by using online booking applications, check-in kiosks, or other mechanisms.

Although the specific service may not always be known before a service is rendered, a basic service description will be required on pre-service assignment agreements to inform a patient's decision as to whether to assign their Medicare benefit. If the actual service rendered differs significantly from the service described in the pre-service assignment agreement (i.e. falls outside the agreed basic service category), then a post-service AoB will need to be completed after the medical service. This could be obtained electronically or in hard copy.

What happens if a patient sees a different practitioner on the appointment day despite completing a pre-assignment?

If the rendering practitioner differs from the practitioner listed in the pre-assignment agreement, it is necessary to complete an updated pre-service assignment before the service (if known), or a post-service assignment agreement with the details of the practitioner who did deliver the service.

Details of the 'data set' are outlined in subsection 65C(4) of the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025. If the information in the AoB agreement does not match the claim, it does not meet legal requirements for that claim.

Is it possible to approve pre-assignments in advance for planned treatments?

Yes. However, the associated claim can only be submitted after the service has been rendered. If the service is not provided or is changed (e.g. the date of service changes, or the service or the practitioner changes), the assignment becomes void and a new AoB agreement is required.

Regulations also provide for an episodic pre assignment agreement to cover multiple known services for a period up to six (6) months. This will enable patients who are scheduled to receive regular medical care (for example patients who receive regular dialysis, are undergoing cancer treatment, or receiving palliative care) to make one agreement which captures all known appointments. This is instead of separate agreements for appointment.

The use of a an episodic pre assignment agreement for up to six (6) months of services will require the information for each service to be specified, and delivered by the same medical professional, on specified dates. If any of the information set out in changes (for example the date of a service is changed, or a different professional renders a service at an appointment), then a new episodic pre or post assignment agreement will be required to support the related claim.

Can the new data set be used before 1 July 2026, and is a Notice of Integration (NOI) required?

Yes. Provided the requirements of both current and new legislation are met, this is acceptable.

Regarding the NOI and connections to Services Australia's systems, further information can be obtained by contacting Services Australia directly.

The best way to stay up to date on software issues is to be signed up to access Services Australia's Health Systems Software Developer Portal. If you are not signed up, information is available at - Get started as a software developer - Health professionals - Services Australia and Home | Health Systems Developer Portal

What will be the process for handling rejected or resubmitted claims during the transition?

Rejections and adjustments will be managed by Services Australia as per existing processes. For all services other than pathology, if the assignment for a claim occurred before 1 July 2026 and the resubmission or adjustment occurs after 1 July 2026, the health professional will need to ensure the patient/claimant has agreed to assign their benefit using a document that complies with the new requirements outlined in the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.

For pathology services, as per regulations the agency will either accept the existing offer to assign (for 12 months) or they will be required to obtain the assignment of benefit again using a document that complies the new requirements outlined in the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.

Please note new versions of the existing forms for these processes will be made available to health professionals to coincide with the 1 July 2026 changes.

Is it possible to have one assignment of benefit for multiple services?

Scenario 1 – Multiple services with the same practitioner on the same day

In this scenario, multiple services may be included under a single AoB agreement if the provided services correspond to those listed and are rendered by the same practitioner. Otherwise, an additional AoB agreement will be required.

Scenario 2 – Multiple services with multiple practitioners from different practices on the same day

In this scenario, separate AoB agreements would be required. Multiple services by a single practitioner may be listed on the same agreement.

Scenario 3 – Multiple services with multiple practitioners at the same practice on the same day

In this scenario, separate AoB agreements would be required. The provided services should correspond to those listed on the AoB agreement by the same practitioner.

What steps should be taken if a patient is unable to assign?

If a patient is unable to assign an AoB agreement, an assignor (i.e. parent, partner, carer, relative, person with power of attorney or friend) could be asked to assign on the patient's behalf. Persons employed by the medical practitioner rendering the medical service cannot be the 'assignor' as there is a perceived financial conflict of interest. If those persons are the parents or carers of the patient, however, it may be considered acceptable for them to assign on the child's behalf.

Practices should consider that the person who makes the assignment is being presented with health-related information for a patient. Protecting the patient's privacy is important. If the patient or an assignor is unable to sign an agreement in person, an electronic signature could be obtained.

In response to concerns raised by stakeholders about the amended Medicare assignment of benefit legislative requirements, regulatory amendments will be made to support a 12-month transition period. This includes enabling verbal assignment of benefit for all bulk billed patients, in all settings.

Use of verbal assignment will not negate the requirement of completed agreements to be retained for 2 years for record-keeping purposes.

For situations where a patient lacks capacity to make their own financial decisions, further information is available on Services Australia's website about acting for someone with Medicare.

What is the assignment of benefit process for public patients in public hospitals?

Public services provided to public patients are funded under the National Health Reform Agreement (NHRA). All components of an episode of public patient care must be provided free of charge and no claims should be made against the Medicare Benefits Schedule (MBS).

If patient's have elected to be private patients, they would assign benefits for bulk billed services the same way as any other setting. This could include pre-service assignment/s if the details are known (e.g. dates, kinds of services, providers, etc). This could be included with private election or at patient check-in, if appropriate.

If a pre-service assignment is not practical, then post-service assignment should be used. This would be similar to the process before 1 July 2026. This could be done with a template containing the required information or form, such as the DB4E.

How will this work in aged care and nursing home settings?

An AoB for bulk billed services is required in aged care settings. Where a patient lacks mental or physical capacity to make their own financial or health decisions, an assignor can do so on their behalf. Under the *Health Insurance Act 1973*, an assignor is a person who would otherwise meet the cost of medical expenses. In practical terms this is usually a carer, partner, parent, or a person with Power of Attorney.

For situations where a patient lacks capacity to make their own financial decisions, further information is available on Services Australia's website about acting for someone with Medicare.

In addition, regulatory amendments have been progressed that would reduce administrative burden for bulk billing GP services through the introduction of an 'enduring' assignment of benefit option for eligible patients. This means that from 1 July 2026 (subject to Executive Council approval), patients registered with MyMedicare, residents of aged care homes, and patients of ACCHOs and AMSs will be able to make an enduring assignment of benefit for ongoing GP bulk billed services, either directly or through a person acting on their behalf.

- A patient registered with MyMedicare will be able to make one enduring agreement to receive services from all general practitioners at their MyMedicare practice, if offered.
- A patient of an ACCHO or AMS will be able to make an enduring agreement with the ACCHO or AMS, and they will be able to have multiple agreements with multiple ACCHs or AMS.
- A patient living in a residential aged care home will be able to make multiple enduring agreements with different practitioners.

Can you give examples of an electronic signature?

From 1 July 2026, an electronic signature is acceptable, provided it reliably identifies the assignor, reliably indicates their agreement, and meets relevant privacy and information technology requirements.

Examples of an electronic signature may include a patient signing on a tablet or touch screen, typing their name into an electronic form where this is used to indicate agreement, clicking 'I accept' on an online form or using a secure digital signature process.

For broader guidance on what may constitute an electronic signature, please refer to the Attorney-General's Department website and the *Electronic Transaction Act 1999*(ETA).

If you require more detailed information, you should review the ETA or seek legal advice.

How does episodic assignment of benefit apply in the context of a home visit?

For a home visit, an assignment of benefit may be made before or after the service is rendered. Where possible, the patient should physically or electronically sign the assignment agreement, noting that regulatory amendments are pending to enable verbal assignment of benefit as part of a 12-month transition period.

If the patient is unable to assign, the assignment can be obtained from the 'assignor,' who would otherwise meet the cost of the medical service if it were not being bulk billed. While this often is a parent, guardian, or carer, it is not limited to these relationships. Persons employed by the medical practitioner rendering the medical service cannot be the 'assignor' as there is a perceived financial conflict of interest. If those persons are the parents or carers of the patient however, it would be considered acceptable for them to assign on the child's behalf.

If the assignment is made before the visit (pre-assignment), it should accurately describe the service expected to be provided based upon the 'basic service description' (located on MBS Online's Download page). If the service provided is different from the service described in the assignment, a new or updated assignment should be completed.

Each patient's assignment should be separately documented. If the same 'assignor' assigns for more than one patient during a home visit, each assignment should clearly identify the relevant patient and service.

What is an enduring agreement?

An enduring agreement allows an eligible patient, or a person acting on their behalf, to assign their Medicare benefits once for future bulk billed services covered by the agreement, rather than completing a new assignment for each service.

From 1 July 2026, enduring agreements are available for:

- A patient registered with MyMedicare will be able to make one enduring agreement to receive services from general practitioners at their MyMedicare practice, if offered.
- A patient of an Aboriginal Community Controlled Health Organisation (ACCHO) or Aboriginal Medical Service (AMS) will be able to make an enduring agreement with the ACCHO or AMS, and they will be able to have multiple agreements with multiple ACCHOs or AMSs.
- A patient living in a residential aged care home will be able to make multiple enduring agreements with different practitioners.

An enduring agreement may be terminated at any time by either party providing written notice to the other party. A patient may also terminate an enduring agreement, even if another person originally entered into the agreement on their behalf. Once written notice is given, the agreement ends after 2 business days.

An enduring agreement will also cease automatically in certain circumstances, including if a patient is no longer registered with the relevant MyMedicare practice, if the practitioner leaves the nominated practice location, if a patient in residential aged care stops residing in an aged care home, or a patient covered under an agreement turns 14 years of age (at 14 years of age, a patient can make their own enduring agreement or choose to have an assignor do it on their behalf).

Where a provider intends to terminate an enduring agreement, they must notify the assignor at least 2 days before the agreement is terminated.

When a Medicare claim is made using an enduring agreement for a MyMedicare registered patient, the provider must notify the assignor in writing within 24 hours of making the claim. The notification must be sent using the method agreed to in the enduring agreement and must include the name of the professional who provided the service, the patient's name, the date the service was provided, and the amount of Medicare benefit claimed. Post service notifications are not required for enduring agreements entered by patients in a residential aged care home or an ACCHO/AMS.
Providers must also retain records of notifications as part of their enduring agreement record-keeping obligations.

Who can enter an enduring agreement?

From 1 July 2026, enduring agreements are available for:

- A patient registered with MyMedicare will be able to make one enduring agreement to receive services from general practitioners at their MyMedicare practice, if offered.
- A patient of an Aboriginal Community Controlled Health Organisation (ACCHO) or Aboriginal Medical Service (AMS) will be able to make an enduring agreement with the ACCHO or AMS, and they will be able to have multiple agreements with multiple ACCHOs or AMS.
- A patient living in a residential aged care home will be able to make multiple enduring agreements with different practitioners.

Medical professionals who are General Practitioners (GPs) within these settings can enter an enduring agreement (this excludes a consultant physician, or a specialist, in a particular speciality other than general practice).

What are the requirements for an enduring agreement?

The table below sets out a high-level summary of the information required for an enduring agreement. For further clarification, refer to the requirements as worded in Health Insurance Amendment (Enduring Agreements) Regulations 2026.

Requirement	MyMedicare	ACCHO / AMS	Residential Aged Care Home
Patient name	✓	✓	✓
Whether the assignor is the patient (Yes/No)	✓	✓	✓
Name of assignor (where not the patient)	✓	✓	✓
If applicable, relationship of assignor to patient (parent, guardian, attorney etc.)	✓	✓	✓
If applicable, patient declaration where patient is 14 years or older and another person is acting as assignor	✓	✓	✓
Signature (electronic or physical) of assignor	✓	✓	✓
Date agreement entered into	✓	✓	✓
Description of professional services covered by agreement (e.g. using MBS Category; Group; Subgroup; or Item/s, or a combination)	✓	✓	✓
Information on how the agreement can be terminated	✓	✓	✓
Method by which notifications will be provided to assignor	✓	Not required	Not required
Name of provider or authorised agent	✓	Name of authorised agent	✓
Practice address or provider number	✓	Practice address or provider number of agent	✓

What services can be part of an enduring agreement?

Any GP services can be entered into an enduring agreement. It can be displayed at a MBS Category, Group, Subgroup, or Item level, or a combination of these, when entering the agreement.

An example list of items for an enduring agreement could include, but is not limited to services eligible for the Bulk Billing Practice Incentive Program.

It is important to note that once the agreement is agreed upon, the provider is required to bulk bill the patient (or assignor) for any future in-scope services until the agreement is terminated. If a provider wishes to change the scope of services under an enduring agreement, the existing agreement will need to be terminated and a new enduring agreement with a revised service scope made.

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All information in this publication is correct as at June 2026