



Australian Government

Department of Health, Disability and Ageing

Assignment of Medicare Benefits for Simplified Billing

Frequently Asked Questions

8 September 2026





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Version Number:	2.0
Date:	8 September 2026
Purpose:	This document provides frequently asked questions and guidance on assignment of Medicare benefits for simplified billing from 1 July 2026.
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1. Assignment of Medicare benefits process

1.1. What is assignment of Medicare benefit?

- Under Medicare and the [Health Insurance Act 1973](#), the Australian Government subsidises the cost of health services. This is the basis for patients to receive Medicare benefits.
- Assignment of Medicare benefits or AOB is the process for a person to assign their right to a Medicare benefit to another party. Medicare benefits are commonly assigned to medical providers for bulk billed services or, for simplified billing services, to a private health insurer or approved billing agent. A list of approved billing agents can be found at: [Find Approved Billing Agents who use ECLIPSE - Health professionals - Services Australia](#).
- This means that if someone else is receiving the Medicare benefit, instead of the responsible person (e.g., the patient), an assignment of Medicare benefit is required.
- Assignment of benefits has been a long-standing feature of Medicare where someone other than the patient is receiving the benefit.

1.2. What is simplified billing?

- Simplified billing is one of the ways a Medicare benefit can be claimed from Services Australia.
- This is used to claim for medical services rendered as part of hospital treatment or hospital-substitute treatment. This includes privately insured patients who are admitted in public, private, and day hospitals.
- Simplified billing does not relate to claims for benefits paid by the private health insurer to the hospital for theatre and accommodation.
- As there is usually a private health insurance (PHI) benefit associated with this Medicare benefit, simplified billing enables the Medicare benefit to be paid to private health insurer or an approved billing agent, and they process the Medicare and PHI benefits to the final beneficiary (e.g., the medical provider).

1.3. How does Medicare claiming work for in-hospital treatments?

- Healthcare providers may submit Medicare claims through different claiming channels, including ECLIPSE or manual claiming processes.
- The process involves the following steps:
 - The provider submits a claim for Medicare benefits to Services Australia.
 - Services Australia confirms provider and patient eligibility.
 - Services Australia assess the claim against the MBS item fee and assessing rules to determine the benefits payable.
 - Services Australia finalises the claim and provides the claim assessment details and payment of 75% of the MBS fee.
 - Payment is made to:
 - patient - if the full service fee was paid upfront by the patient to the practitioner. This is EasyClaim.
 - practitioner - if the patient has paid the gap between the full fee and the 75% only. This is Pay Doctor via Claimant.
 - relevant insurer (if the patient has private health insurance). This process is referred to as simplified billing.

1.4. What is the simplified billing pathway?

- Simplified billing is the term given to the claiming process that allows the Medicare benefit to be paid to the private health insurer or approved billing agent, rather than directly to the patient.
- The process for approved billing agents includes additional steps, with the provider first providing the claim to the agent. Once the claim is assessed by Services Australia, the payment workflows through the agent before payment is provided to either the provider or insurer.

1.5. What is informed financial consent (IFC)?

- IFC is the process of ensuring a patient (or other eligible person/assignor) is given clear, accurate and timely information about the expected costs of their care before they agree to proceed with treatment and before they agree to assign the Medicare benefits associated with that treatment.
- In the context of AOB for simplified billing services, IFC underpins a valid implied or requested assignment because the assignor must understand the financial implications of assigning their Medicare benefit to another party (such as a private health insurer or approved billing agent), who they are assigning it to, and which benefits will be assigned.
- IFC is a long-standing feature of Medicare and applies to all healthcare providers including pathology and imaging.

1.6. What is bulk billing?

- Bulk billing is another claiming method for a Medicare benefit to be processed with Services Australia. This is a different claiming method to simplified billing.
- This is when a medical provider receives the Medicare benefit on behalf of the patient and accepts the Medicare benefit as full payment for the service. This can occur in any setting, including primary care (e.g., General Practitioner services) or hospitals (e.g., outpatient hospital or admitted patient services).
- The requirements for simplified billing and bulk billing assignments vary (see **Appendix A**). More information on assignments for bulk billed services can be found in the [Health Insurance Regulations 2018 - Federal Register of Legislation](#).

1.7. How can a provider determine which assignment of benefit pathway to use?

- If a patient has private health insurance and the Medicare benefit is to be paid by government to a private health insurer or an approved billing agent, simplified billing assignments apply.
- If the Medicare benefit is to be paid by government to a health care provider and that health care provider is accepting the Medicare benefit as full payment for the service, bulk billing assignments apply.
- If the Medicare benefit is to be paid by government to the patient (or a responsible person), the benefit will not need to be assigned. This means the benefit was paid following a patient claim.

1.8. Why is simplified billing a good process for patients?

- Simplified billing enables claims to be processed on behalf of the patient. This means that patients do not need to pay the entire cost of services upfront and they do not need to manage multiple Medicare and PHI claims and health care invoices.
- Simplified billing provides a streamlined process for health care providers, insurers and Services Australia to manage these claims and reduce the financial and administrative burden on patients.

1.9. Who can be the assignor?

- The assignor can be any eligible person to whom a Medicare benefit is, or will be payable to, in relation to a professional service (medical service). That is, they are the person who is or will be financially responsible for the professional service that is eligible for a Medicare rebate.
- For simplified billing assignments, the assignor can be anyone who is covered by a private health insurance policy or anyone authorised to act on their behalf.
- In most cases, the assignor is the patient receiving the treatment.

1.10. How is assignment managed if a patient is incapacitated for an extended period?

- In majority of cases, IFC and AOB will occur prior to treatment or prior to admission. However, in instances where a patient is incapacitated or unable to assign benefits for treatment that are not already included in their original assignment, the law allows assignment to be made by the eligible person (assignor) or by a person lawfully authorised to act for the patient.

1.11. What happens to the payment of benefits if it is not processed through simplified billing?

- The assignment of benefit processes underpins billing pathways where the Medicare benefit does not go to the patient. If the claim is processed through a patient claim for a person with private health insurance, the patient is responsible for the full amount of the medical services payable to the medical practitioner and arranging reimbursement from their insurer and Medicare.

2. Requirements from 1 July 2026

2.1. When did the assignment of benefit changes commence?

- The new requirements commenced on 1 July 2026. This means that any Medicare-eligible service that are rendered from 1 July 2026 and claimed through simplified billing will need to be assigned under the new requirements.

2.2. What requirement apply if the service was provided before 1 July 2026, but the claim is submitted on or after 1 July 2026?

- For services rendered before 1 July 2026, the assignment should be supported by the requirements that applied at the time the service was rendered.
- Records should be retained to show that a valid assignment occurred for the service, including any record required under the pre-commencement process and any information needed to support the claims declaration.

2.3. What is the legislation that underpins the assignment of benefit changes?

- The high level AOB requirements are set out in the [Health Insurance Act 1973](#) (HI Act) whilst the details of each requirement are set out in the [Health Insurance Regulations 2018](#) (HI Regulations).
- There are currently 4 legislative amendments that amend the HI Act and the HI Regulations from 1 July 2026:
 - [Health Insurance Legislation Amendment \(Assignment of Medicare Benefits\) Act 2024](#) (AOB Act 2024)
 - The AOB Act 2024 contains the main amendments to the assignment of benefit process. This includes: the introduction of two assignment pathways: implied assignment and requested assignment; record keeping requirements, and notification requirements.
 - [Health Insurance Amendment \(Assignment of Medicare Benefits and Other Measures\) Regulations 2025](#) (AOB Regulations 2025)
 - The AOB Regulations 2025 sets out the particulars required in requested assignments, which documents must be kept to support an assignment, and sets out the requirement for an assignment of benefit declaration as part of claims.
 - [Health Legislation Amendment \(Miscellaneous Measures No. 1\) Act 2025](#) (HLA Act 2025)
 - The HLA Act 2025 sets the commencement date of the AOB changes to 1 July 2026 and amend the notification requirements.
 - [Health Insurance Amendment \(Episodic Agreements and Simplified Billing Assignments\) Regulations 2026](#) (AOB Regulations 2026)
- These amendments do not introduce any new requirements and are intended to align the regulations with the HLA Act 2025 and AOB Act 2024 with regards to the following:
 - who can make an assignment (i.e., any person covered by a complying health insurance policy)
 - remove the notification requirements on health professionals, hospitals, and organisations for assignment requests as modified;
 - enable the person rendered the professional service, in addition to the assignor, to receive a notification from the private health insurer or the approved billing agent when Medicare benefits are received on their behalf; and update record-keeping requirements.

2.4. What are the key requirements for services claimed through simplified billing to be assigned?

- The patient is covered by a private health insurance policy for the medical services that are, or will be, rendered to them.
- An assignment is facilitated under the 'implied' or 'requested' assignment pathways.
- A Medicare claim is made for the rendered service.

2.5. What are the two pathways a simplified billing assignment can occur?

- Implied assignment (assignment by operation of law):
 - Implied assignment can occur where the conditions in the legislation are met. In this context, an assignment occurs without the patient or assignor needing to provide a separate written request, signature or approval at the time of claiming.
 - The key requirement is that a medical provider, hospital or organisation has an arrangement with a private health insurer that relates to both the provision of medical services to patients covered by that insurer, and the insurer's liability to pay for those services.
 - The arrangement must also apply to the services being claimed.
- This means no explicit patient signature or separate patient request is required for the assignment, because the assignment arises by operation of law where the conditions for implied assignment are met. For example, if a service is billed through a medical purchase provider agreement (MPPA) and that arrangement applied to the service, the assignment should occur through the implied assignment pathway.
- Requested assignment:
 - This assignment pathway is available when there is no insurer arrangement that applies to the service (i.e. implied assignment is not available or does not apply). This involves a manual request facilitated by the health professional, the hospital, or an organisation.

2.6. Is Services Australia's Approved Assignment Form required to be used after 1 July 2026?

- The legislative changes commencing on 1 July 2026 removes the requirement for an approved form to be used to assign a benefit. This has been replaced by the AOB changes outlined in Item 2.2.
- Note that parts of this approved form may be inconsistent with the new requirements.

2.7. How is the assignment made to the approved billing agent?

- Under implied assignment, if the claim for the services is made by the approved billing agent, then the Medicare benefit for the service will be taken to be assigned to them. Otherwise, it will be assigned to the private health insurer if the private health insurer is receiving the Medicare benefit.
- The assignment is made to the approved billing agent if they are named in the assignment request that the assignor has agreed to.

2.8. Are there special assignment conditions or variations required that depend on the type of service (e.g., surgical services, anaesthesia, surgical assistant services, pathology services, or diagnostic imaging services)?

- No, the assignment requirements are consistent across the different specialties and types of medical services including pathology and diagnostic imaging services. If the patient or assignor would like to assign their right to the Medicare benefit, the same process must be followed regardless of the type of service or medical speciality. The difference will be in whether the assignment occurs through the implied or requested pathways.

2.9. When can an assignment of benefit occur?

- An assignment can occur at any time before a Medicare claim is made.
- When a claim is made, the provider will have to include a declaration in the claim that they have satisfied assignment requirements in making the claim. This declaration can be either by form (for manual assignments) or by selecting that a declaration has been made in ECLIPSE.

- Similar to existing IFC best practice, AOB can be facilitated as soon as practicable or when the patient has capacity to do so.
- There are also automatic assignment options (implied assignment) that a provider can use for the service to be assigned to a private health insurer or approved billing agent.
- If implied assignment is not available and the hospital is facilitating an assignment for the entire admission, the medical provider should communicate with the hospital and confirm if they are covered by that assignment request.
- If implied assignment is not available, the hospital is not facilitating the assignment request, and the patient/assignor wants to assign the benefit, the provider/s will have to facilitate an assignment for services they are providing for that admission. The provider should give the hospital a copy of the completed assignment request for the hospital's records.

3. Assignment of benefit pathways: Implied assignment

- 3.1. What kind of arrangements can substantiate 'implied assignment' (assignment by operation of law)?
 - Implied Assignment is an automatic assignment of the Medicare benefit to a private health insurer or approved billing agent. If a medical provider, hospital, or organisation has an arrangement with an insurer regarding medical services and fees, then implied assignment can occur.
 - Examples of these arrangements include gap cover agreements and medical purchase provider agreements (MPPAs).
 - In this pathway, the key actions are to keep the relevant records and make the claims declaration.
 - There is no requirement for a patient or assignor's physical agreement to assign the benefit under implied assignment.
- 3.2. The hospital has an arrangement with the insurer regarding medical services (separate to hospital contracts relating to accommodation benefits), can this support implied assignment?
 - Yes, as per Item 3.1, if the arrangement relates to the provision of medical services to patients covered by that insurer and the insurer's liability to pay for those medical services through that arrangement and it applies to the service, then implied assignment can occur.
- 3.3. My organisation provides hospital-substitute treatment and we have an arrangement with private health insurers. Will the implied assignment pathway apply for simplified billing claims?
 - The legislative requirements for insurer arrangements enable a broad range of arrangements to substantiate implied assignment. As per Item 3.1, if the arrangement relates to the provision of medical services to patients covered by that insurer and the insurer's liability to pay for those medical services through that arrangement and it applies to the service, then implied assignment can occur.
- 3.4. If the claim is made through Eclipse Inpatient Medical Claims – Agreements or Inpatient Medical Claims – Schemes, does this mean 'implied assignment' applies?
 - If the arrangement between a provider and the insurer only relates to the use a billing method (e.g., claiming through ECLIPSE), then this will likely not support implied assignment.
 - As per Item 3.1, an arrangement that supports implied assignment must relate to an agreement between the health insurer and either the medical provider, hospital, or organisation regarding the provision of services to patients covered by that insurer and the insurer's liability to pay for those medical services through that arrangement and it applies to the service.
- 3.5. If a doctor charges an out-of-pocket amount, is requested assignment required rather than implied assignment?
 - Implied assignment can occur if an insurer arrangement applies to the service. Some insurer arrangements allow for out of pockets to be charged to the patient eg. known gap arrangements. In these instances, an implied assignment can still occur.

4. Assignment of benefit pathways: Requested assignment

4.1. When is requested assignment required?

- A requested assignment is required if the patient or assignor asks to assign their Medicare benefit to their private health insurer or an approved billing agent and the implied assignment pathway is not applicable or available for the medical service.

4.2. Is there wording that can be used in IFC or AOB documentation to cover the requested assignment requirements?

- The below wording captures majority of the requested assignment particulars set out in clause 65D of the [*Health Insurance Amendment \(Assignment of Medicare Benefits and Other Measures\) Regulations 2025*](#):
 - For assignment requests facilitated by the operator of the hospital or organisation for hospital treatment:
 - 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]*.
 - For assignment requests facilitated by a health professional for hospital-substitute treatment:
 - 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-substitute treatment relating to *[description of condition/treatment/services]* provided by or on behalf of *[name of health professional]* at *[location where the professional service will be/was rendered]* rendered on *[date of service]*.

4.3. What information is required to be included in the requested assignment?

- Refer to **Appendix A**.

4.4. What kind of approval is required from the assignor to complete an assignment request?

- Under the *Electronic Transactions Act 1999* (ETA 1999), the essential requirements for an electronic signature are that it reliably identifies the person and indicates their approval of the information communicated. The ETA 1999 is intentionally broad and technology neutral. The requirement is that the approval is conducted in a written format and that it demonstrates intent and identity of the assignor in the document.

4.5. What is the 'description of hospital treatment or hospital-substitute treatment' that is required as part of the assignment request?

- This 'description of hospital treatment or hospital-substitute treatment' is a general description of the condition the patient will be treated for, the treatment that will be provided to the patient, and/or the services that will be rendered to the patient during the episode of hospital or hospital-substitute treatment. The description should cover all relevant services that needs to be covered by that assignment, including surgical, anaesthetic, pathology, diagnostic imaging, and any other relevant services.
- For cardiac-related hospital treatment, an example of a description to satisfy this requirement could state: "the investigation and treatment of heart, heart-related conditions and vascular

system, including any associated pathology, diagnostic imaging and referred professional services”.

- It is important to note that this description requirement is only for the purposes of requested assignments to convey to the patient the range of treatment or services that will be covered by the assignment. This should not be used for the purposes of determining PHI coverage and a copy of the completed requested assignment is not required to be provided to private health insurers for any audit or compliance purposes.
- The description can use one or more relevant categories where clinically appropriate to reflect the planned services within the admission and should also specifically include that supporting services (e.g., pathology and diagnostic imaging services) are also covered by the assignment request as per the above example.

4.6. If a hospital obtains a single assignment request that covers the entire admission, including pathology and diagnostic imaging services, can other service providers rely on the hospital’s AOB record for audit purposes?

- The hospital must keep a copy of the assignment request for audit purposes. A valid hospital facilitated assignment request can cover pathology and diagnostic imaging services where those services are within the scope of the request. Any medical provider who is relying on the assignment request facilitated by the hospital should confirm they are covered by the request so they can accurately complete the assignment of benefit declaration when making the claim.

4.7. What is the duration of an assignment?

- One assignment can cover all of the medical services that are provided to the patient during the entire admission or episode of care. The assignment must include all the necessary information that reflects the medical services rendered.

4.8. Can an assignment request cover multiple admissions for a single course of treatment?

- An assignment can cover a series of admissions related to a course of treatment if the information set out in the assignment request (which the patient agrees to), relates to each individual admission. For example, a single assignment request form for dialysis treatment should reflect this is a course of treatment in the description of hospital treatment and also set out each date of admission or date of service that is part of the course of treatment.
- Using a date range or time period does not sufficiently capture each episode of care or each date of admission to satisfy assignment of benefit requirements.

4.9. Does an assignment request need to include the names of all medical providers or health professionals covered by that assignment?

- A list of names of providers covered by the assignment request should be included in the assignment request. Otherwise, an option is for the hospital (for hospital treatment) or the organisation (for hospital-substitute treatment) to include a statement in the assignment that providers they have authorised to provide services during the assignor or patient’s hospital or hospital-substitute treatment is covered by the assignment request.
- If a medical provider is facilitating their own assignment request, they should include their own name and relevant details.

4.10. Does each medical service require an individual assignment request?

- No, one assignment can cover multiple or all medical services within the scope of the assignment request including pathology and diagnostic imaging services, provided those services are covered by the description in the assignment request and other legislative requirements are met. Any material change to scope must be handled in accordance with the rules for modifying an assignment.

4.11. Can an assignment request cover multiple approved billing agents for a single admission?

- A single assignment can also cover multiple approved billing agents, as long as it is clear in the assignment which services are being assigned to which billing agent. An assignment must identify

the party to whom the Medicare benefit is assigned. If multiple parties will receive benefits, separate assignments or clear identification of the assignee for each claimable component may be required to ensure the payment is authorised and auditable.

4.12. Who can facilitate an assignment request for an admission for hospital treatment?

- Assignment should occur as part of informed financial consent between a patient and medical practitioner. In practice, the practitioner may be assisted with this process by administrative staff or the hospital.
- A hospital can also facilitate an assignment of benefit to cover an admission, but this is not a legal requirement.
- Because of this, manual assignment requests can be made to the hospital and facilitated by the hospital because medical services provided as part of hospital treatment (which may be claimed through simplified billing) are provided under the hospital's authority and management and rendered with the hospital's involvement.
- In practice, a hospital may choose to facilitate an assignment for an entire admission (as part of the private patient election process or at the same time as admission). Pathologists, surgeons, radiologists, and any other medical provider who cannot use implied assignment can then confirm with the hospital if a requested assignment occurred and if that medical provider is covered by the assignment so they can submit the appropriate claims declaration (similar to confirming if a patient has elected to be treated as a private patient or the patient is covered by a PHI policy for the service so they can claim PHI benefits).
- The structure and content of informed financial consent and assignment of benefits documentation is flexible if it meets the legislative requirements. The [National Private Patient Hospital Claim Form](#) is an example of these requirements.

4.13. Can the [National Private Patient Hospital Claim Form](#), private patient election forms, admission forms or other existing IFC forms be updated to include requested assignment requirements?

- Existing forms can incorporate the information that must be included in a requested assignment to streamline the assignment process. The requested assignment can be set out in any written format (digital or paper) and does not have to be a standalone document.
- The National Private Patient Hospital Claim Form or HC21 Form is administered by Private Healthcare Australia (PHA). To enquire about updates to this form, PHA can be contacted at: admin@pha.org.au.

5. Complications and unplanned treatment

5.1. What happens if there are complications or unplanned urgent treatment during the patient's admission?

- If the additional services provided to the patient are related to the services covered by the original assignment request (i.e., the additional services are related to the services set out in the 'description of hospital or hospital-substitute treatment'), then these services will be automatically assigned (implied or requested) as per the original service.
- For example, if the requested assignment was related to an elective surgery but there were complications during the surgery, any service required to treat that complication is automatically covered by the original assignment request.

5.2. Does an assignment request need to be modified if there were complications related to the original assigned service/s?

- No, services provided that are due to a complication or any other unplanned, urgent treatment related to the original service are automatically covered under the same pathway as the original assigned service.

6. Modified requested assignments

6.1. When do an assignment request need to be modified?

- An assignment request needs to be modified if there are additional services provided to the patient that are not covered by the original assignment request or are not considered complications or unplanned, urgent treatment.
- An assignment request also needs to be modified if there are changes to the information that the patient has previously agreed to after they have received the service (e.g., the patient approved a request with the incorrect date of admission after they have already been admitted).
- Example of when an assignment request needs to be modified:
 - As per Item 4.5, an example of a description of hospital treatment in the requested assignment (as agreed by the patient) states: *“the investigation and treatment of heart, heart-related conditions and vascular system, including any associated pathology, diagnostic imaging and referred professional services”*.
 - If the patient also required a knee replacement during the same admission but was unrelated to the above-mentioned ‘investigation and treatment of heart, heart-related conditions and vascular system’, the requested assignment needs to be modified.
- Example of when an assignment request does not need to be modified:
 - Following on the above example, if the patient experiences a fall during their admission due to symptoms of the heart-related condition, associated treatment does not require a modified assignment request. Refer to Item 5 Complications and unplanned treatment of this document.
 - A modified assignment requested is only completed if the patient has provided written agreement to the changes.

6.2. For modified assignments, can clinical categories be used to describe changes?

- As per Item 4.5, clinical categories can be used within the description of hospital treatment required for requested assignments. As such, if an assignment requested needs to be modified, clinical categories can be added or amended in the description to cover the relevant services rendered.
- If a pathology or diagnostic imaging provider must refer a service to another provider, or additional pathology or diagnostic imaging services are required, those services are treated in the same way as other medical services rendered by, or on behalf of, a medical provider as part of hospital treatment or hospital-substitute treatment. The relevant provider may rely on the implied assignment or requested assignment pathway, depending on which pathway applies to the service.

7. Notifications

7.1. What must be included in the notification that is sent by the private health insurer or approved billing agent when they receive assigned Medicare benefits?

- Refer to **Appendix B**.
- The notification can be in any written format.

7.2. Who needs to send a notification to the patient or assignor?

- This will depend on who is receiving the assigned Medicare benefit at first instance from government, either the private health insurer or the approved billing agent.
- For benefits assigned and received by approved billing agents, insurers are not required to send a notification for the PHI benefit component of the medical service.

7.3. Who must be notified by the private health insurer or the approved billing agent?

- Notifications are required to be sent to either the assignor or the patient within 6 months of the private health insurer or the approved billing agent receiving the Medicare benefit. These notifications are to be sent in the manner that the assignor or patient prefers, such as communications being directed to the main policyholder or which policy holders have set their contact details with the insurer.

- This change is intended to be in line with existing communication processes for PHI policyholders and communications with patients whose claims are processed by approved billing agents.
- Insurers should confirm with policyholders their communication preferences (e.g., notifications to be sent via email or physical mail), who the notifications should be sent to, and who the patient/assignor authorises to receive these notification (e.g., the main policyholder, for instances where it differs from the patient).

7.4. Can a private health insurer or the approved billing agent send a notification that includes multiple services?

- Yes, a private health insurer or the approved billing agent can combine the notifications for multiple services (which can be for different dates of service or rendered by different providers) into a single notification, provided the notification is sent in writing, includes all the necessary information and sent within the required period.
- Notifications can also include other information that is above the minimum requirements. For example, a private health insurer or the approved billing agent can also include the associated private health insurance benefit paid for the service.

7.5. Should the completed assignment request be sent to the insurer to confirm who is the assignor?

- There is no requirement for the completed assignment request to be sent to the private health insurer or approved billing agent.
- Insurers and billing agents can send the notification to the patient to whom the Medicare benefit pertains to, even if this differs from the person who completed the assignment request.

7.6. Does a private health insurer or approved billing agent need to send a notification if a Medicare claim is adjusted, if a Medicare benefit is recovered or refunded, or if the PHI benefit is recovered or refunded?

- The notification obligation under section 127(3) of the AOB Act 2024 is linked to the payment of a Medicare benefit to the insurer or approved billing agent. If there are further changes to a simplified billing claim that has already been assigned and paid to a private health insurer or approved billing agent, an additional notification is only required if the private health insurer or approved billing agent receives Medicare benefits.

7.7. Can a policy holder log in to their private health insurance account and access information relating to paid Medicare benefits that way instead of a notification?

- A notification is still required to advise the patient that assigned benefits have been processed and received on their behalf. A private health insurer can also send communications to the patient or policy holder to view the assignment of benefits notification through their account.

7.8. What if the patient or assignor does not wish to be sent a notification regarding assigned Medicare benefits?

- The notification is a legal requirement that ensures assignors and patients are aware of how Medicare benefits that they are entitled to are being processed on their behalf. An approved billing agent or private health insurer can provide the patient or assignor with options on how they can receive this notification.

7.9. Can the private health insurer refer the patient or assignor to their claims history instead of sending a notification?

- No, the insurer cannot refer the patient or assignor to view their broader claims history to meet the notification requirements. The notification must contain the necessary information to specify the assigned Medicare benefits received by that insurer.

7.10. What if the patient or assignor asks for the notification to be provided in another manner than the private health insurer's or approved billing agent's usual process?

- If the member requests the notification be provided in a different written manner, the insurer or approved billing agent must provide this notification for assigned benefits as agreed upon with the patient or assignor. For example, if the member specifically requests that the notification is

provided via physical mail, the insurer or approved billing agent must comply with that request or agree upon a different method with the patient or assignor.

7.11. Can the private health insurer or approved billing agent send the patient or assignor communications to direct them to access the notification via an online account or portal?

- A notification is still required to advise the patient that assigned benefits have been processed and received on their behalf. A private health insurer can also send communications to the patient or policy holder to view the assignment of benefits notification through their account.
- If the patient or assignor was sent this communication but does not create an account or access their account, the notification within the portal must still be readily accessible so as to be useable for future or subsequent reference. That is, if the patient or assignor does not immediately create an account or access their account, or does not access their account, the notification will still be available in the account/portal regardless and the member can access it in the future.

7.12. Does the health professional, the hospital, or an organisation need to provide a notification to the patient or assignor?

- The requirement for a health professional, the hospital, or an organisation to send a notification when a requested assignment is modified has been removed.
- This notification requirement, which was set out in subsection 127(5) of the AOB Act 2024 was replaced by the amendments made by the HLA Act 2025. Instead, the health professional, the hospital, or an organisation is required to provide the assignor with a copy of the modified requested assignment, if asked. This aligns with subsection 127(4) of the AOB Act 2024 which requires the health professional, the hospital, or an organisation to provide the assignor with a copy of the requested assignment, if asked.

8. Record-keeping

8.1. Why are record-keeping requirements important for assignment of Medicare benefits?

- Recordkeeping is required to evidence that a valid assignment of Medicare benefits has occurred where the benefit is paid to a private health insurer or approved billing agent rather than the patient. Records support compliance, audit, and payment integrity activities undertaken by Services Australia and the department.

8.2. Who is responsible for keeping assignment of benefit records?

- Refer to **Appendix C**.

8.3. If assigned medical services rely on a hospital-facilitated requested assignment, who must produce it?

- The record-keeping obligations for assignment requests are the responsibility of the hospital.

8.4. What records must be kept for a requested assignment?

- For requested assignments under simplified billing, records must demonstrate that:
 - the assignor agreed in writing to assign their Medicare benefit;
 - all required particulars were included in the assignment request (such as service description, assignee, and dates); and
 - the assignment relates to the services to be or that are claimed.
- The assignment request itself does not need to be submitted with the claim but must be retained for compliance or audit if requested.

8.5. What records must be kept for an implied assignment?

- For implied assignments, records must substantiate that a qualifying arrangement exists between the insurer and either the medical provider, hospital, or organisation.
- These records must be sufficient to demonstrate that the conditions for implied assignment were met at the time the service was rendered.

- 8.6. Do assignment records need to be sent to Services Australia or insurers?
- No. Assignment requests and supporting records do not need to be submitted as part of claiming. However, Services Australia or the department may request copies during compliance monitoring, audit, or investigation activities.
- 8.7. How long must assignment of benefit records need to be kept?
- Refer to **Appendix C**.
- 8.8. Are records required if the patient makes their own Medicare claim?
- No, not under assignment of benefit requirements. Where the patient is billed directly and receives the Medicare benefit themselves (patient claim), an assignment of benefit is not required and therefore no AOB record-keeping obligations apply.

9. Online Eligibility Check Web Services (OEC)

- 9.1. What are the changes to Services Australia's Online Eligibility Check Web Services?
- Private health insurers will be required to complete two new fields in the insurer OEC response:
 - Product Tier – this relates to the product tier of the PHI policy
 - Additional Clinical Categories – this is required for Plus products (as set in the Product Tier) and must include any clinical categories that are covered by the PHI policy that are above the mandatory product tier requirements.
 - The purpose of this change is to standardise the coverage information that medical providers and hospitals receive. This also makes it easier and simpler for medical providers and hospitals to check patient eligibility.
- 9.2. Why are changes to OEC required?
- Having a patient's PHI coverage information early supports clear and accurate informed financial consent discussions and assists providers in deciding to utilise their gap cover arrangement or not, particularly in instances where the proposed MBS items for the service are covered by multiple clinical categories.
 - This helps reduce the risk of patients experiencing unexpected out-of-pocket costs or the provider not facilitating the appropriate assignment.
- 9.3. The OEC insurer response does not contain the Product Tier and Additional Clinical Categories information.
- From 1 July 2026, if these fields are not available in your software, please contact your software vendor at first instance. However, if the fields are not completed accurately or appropriately by the insurer, please contact the department at AssignmentofBenefit@health.gov.au.

10. Claiming using ECLIPSE

- 10.1. How is the AOB claims declaration made through ECLIPSE?
- For ECLIPSE claims, Services Australia has introduced new declaration fields and an acknowledgement button within ECLIPSE. The person making the claim must select the relevant assignment pathway and acknowledge that the applicable assignment of benefit requirements have been met.
 - For manual claims, the declaration should be included in the claim documentation submitted with the claim.
 - The below wording (or similar) can be included in the manual claim:
 - For claims for benefits assigned through implied assignment: "This claim for Medicare benefits has been assigned under implied assignment."
 - For claims for benefits assigned through requested assignment: "This claim for Medicare benefits has been assigned under requested assignment."

10.2. What is the AOB claims declaration?

- The AOB claims declaration refers to a new requirement that must be included in all claims for assigned Medicare benefit if the Medicare benefit is to be paid by government to a private health insurer or approved billing agent at first instance. This takes the form of a field in ECLIPSE for online claims.

10.3. How is the AOB claims declaration included in an ECLIPSE claim?

- For ECLIPSE claims, the assignment of benefit declaration is made electronically as part of the claim submission process.
- Services Australia has introduced new declaration fields and an acknowledgement button within ECLIPSE for the person making the claim.
- The person making the claim must select the assignment pathway that applies to the service:
 - Implied assignment where an insurer arrangement applies to the service.
 - Requested assignment where the service is assigned through a requested pathway.
- By selecting the relevant assignment pathway and submitting the claim, the person making the claim is declaring that the applicable assignment requirements have been met.

10.4. Who is required to make the AOB claims declaration?

- It is the responsibility of the person making the claim for Medicare benefits (either the hospital, medical provider, organisation, or approved billing agent) to attest that they have satisfied the assignment requirements of paragraphs 20A(2)(a) to (c) and (e) of the AOB Act 2024 in making that claim.
- For example, this means that if a Medicare benefit for a professional service is assigned under a requested assignment, the responsible provider has facilitated the assignor's request to assign their right to a Medicare benefit. This includes providing the assignor with the information required in a requested assignment, for which the assignor has provided written agreement to.

10.5. How do I determine whether to select implied assignment or requested assignment in an electronic claim?

- If an insurer arrangement applies to the service (for example, a Gap Cover arrangement or Medical Purchase Provider Agreement), the declaration should be made under implied assignment.
- If an insurer arrangement does not apply to the service and the Medicare benefit has been assigned through a requested assignment, the declaration should be made under requested assignment.
- Where both a requested assignment and an insurer arrangement apply to the service, the declaration should be made under implied assignment.

10.6. What should be considered before selecting the ECLIPSE acknowledgement button?

- Before selecting the acknowledgement button, the person making the claim should confirm that the relevant assignment pathway applies to the service.
- The person making the claim should also ensure records are available to support the declaration if requested for compliance or audit purposes.

10.7. When should the AOB declaration be made under implied or requested assignment?

- Insurer arrangement applies to the service (e.g., Gap Cover, MPPA, etc.)
 - Declaration to be made under implied assignment.
- Insurer arrangement does not apply to the service (e.g., doctor has Gap Cover but is not using it for the service, doctor does not have an insurer arrangement)
 - Declaration to be made under requested assignment.
- Insurer arrangement applies to the service, but doctor is also covered by a requested assignment through the hospital
 - Declaration to be made under implied assignment.

10.8. Is there a specific simplified billing assignment pathway that must be used if the claim is made either through ECLIPSE or manually?

- It is not a condition under the implied and requested assignment pathways for a claim to be a submitted through a particular simplified billing method. For example, implied assignment can still occur for manual claims as long as an insurer arrangement applies to the service being claimed. However, depending on the insurer arrangement, a condition of that arrangement may be submission of claims through a certain method (e.g., through ECLIPSE only or through manual claims only) for the arrangement to apply.

10.9. Does a completed assignment request need to be submitted with the Medicare claim?

- No, an assignment request does not need accompany the claim for Medicare benefits.

10.10. Will a Medicare claim be rejected if it does not contain the AOB claims declaration?

- The legislation requires that a claim for a Medicare benefit assigned to a private health insurer or approved billing agent must contain a declaration that AOB requirements have been met in making that claim.
- The AOB claims declaration is a legal requirement that must be included in any Medicare claim for privately insured patients if government is paying the Medicare benefit to another party (private health insurer or approved billing agent) who is not the patient.

10.11. What does a private health insurer have to do if a Medicare claim the insurer is transmitting to Services Australia does not have an appropriate claims declaration?

- The insurer should return the claim to whoever has submitted it. The claims declaration is a legal requirement which must be included in the claim if the Medicare benefit is assigned to the private health insurer.

10.12. What happens if the claim was submitted with the incorrect claims declaration?

- Whoever has submitted the claim will need to keep the required records for the correct assignment that supports the claim and provide these in the event of compliance or audit activity by the department or Services Australia.

10.13. What should insurers do if a manual, medical claim does not contain the medical provider's assignment of benefit declaration?

- The assignment of benefit declaration is a legal requirement that must be included in all simplified billing claims. Medical providers will need to submit this declaration as part of the claim, similar to other claiming particulars such as date of service or Medicare Benefits Schedule (MBS) item. The assignment of benefit declaration indicates that Services Australia can legally pay the benefits for that medical claim to another party who is not the patient. The insurer should return manual, medical claims that do not contain this declaration to the party that submitted the claim.

10.14. Are insurers required to match the requested assignment particulars (e.g., the description of hospital treatment) with the Medicare claim for an assigned benefit?

- No, any compliance relating to the assignment pathway conducted, the assignment request and its contents, and the Medicare claim for an assigned benefit is the responsibility of Services Australia and the department. Note that assignment requests are not legally required to be provided to any other party besides the assignor or government, if required.

10.15. What if we are not ready to implement system changes by 1 July 2026?

- Stakeholders are advised to ensure they keep accurate records of assignments, notifications (if applicable), and any other relevant records that evidence the assignment process. The department and Services Australia are aware that there may be some system limitations with regards to the new AOB requirements. The department's compliance monitoring and assessment processes consider:
 - information and data alongside policy and clinical advice;
 - the context of the broader environment, including recent changes to rules/requirements that industry must adapt to, particularly those that require system changes;

- stakeholder advice to better understand compliance concerns, including extenuating circumstances that may have occurred during the data period under review.
- More details can be found in the department's [Health Provider Compliance Strategy 2025–30](#).

11. Manual claims

11.1. Who is required to make the AOB claims declaration for a manual claim?

- It is the responsibility of the person making the claim for Medicare benefits (either the hospital, medical provider, organisation, or approved billing agent) to attest that they have satisfied the assignment requirements of paragraphs 20A(2)(a) to (c) and (e) of the AOB Act 2024 in making that claim.
- For example, this means that if a Medicare benefit for a professional service is assigned under a requested assignment, the responsible provider has facilitated the assignor's request to assign their right to a Medicare benefit. This includes providing the assignor with the information required in a requested assignment, for which the assignor has provided written agreement to.

11.2. What is an AOB claims declaration for a manual claim?

- The AOB claims declaration refers to a new requirement that must be included in all claims for assigned Medicare benefit if the Medicare benefit is to be paid by government to a private health insurer or approved billing agent at first instance. This takes the form of a claims declaration document for manual claims. There is no designated structure of this document as long as it meets the legislative requirements.

11.3. What wording can be included in manual claims to make the assignment of benefit claims declaration?

- The AOB claims declaration must also be included in manual claims.
- For manual claims, the declaration should be included as part of the claim documentation submitted with the claim.
- The below wording (or similar) can be included in the manual claim:
 - For claims for benefits assigned through implied assignment: "This claim for Medicare benefits has been assigned under implied assignment."
 - For claims for benefits assigned through requested assignment: "This claim for Medicare benefits has been assigned under requested assignment."

Appendix A – Assignment of benefit requirements – information to be provided to the patient or assignor as at August 2026

This table sets out the particulars that must be included in simplified billing assignments. This table highlights the differences in the requirements for each type of assignment and must be used for **comparison or reference purposes only**. For detailed information on what must be included in an assignment, please refer to the [Health Insurance Regulations 2018](#), as it will be amended by the [Health Insurance Amendment \(Assignment of Medicare Benefits and Other Measures\) Regulations 2025](#) and [Health Insurance Amendment \(Episodic Agreements and Simplified Billing Assignments\) Regulations 2026](#) on 1 July 2026.

For updates on bulk billing assignment of benefit changes and legislation, please refer to the department's [Improving the assignment of benefit process](#).

	Simplified Billing (Medicare benefits received by a private health insurer or approved billing agent)			Bulk Billing – Episodic Agreements (Medicare benefits received by a medical provider)	
Assignment Type	Implied Assignment	Requested Assignment (Hospital Treatment)	Requested Assignment (Hospital-substitute Treatment)	Pre-service Assignment (All settings)	Post-service Assignment (All settings)
Patient's details	Not required*	Patient's details	Patient's details	Patient's details	Patient's details
Patient's PHI details	Not required*	Name of patient's private health insurer, and the patient's membership number or PHI identifier	Name of patient's private health insurer, and the patient's membership number or PHI identifier	Not required*	Not required*
Who is the request being made to	Not required*	Name of operator of the hospital	Name of organisation or health professional	Not required*	Not required*
Date of admission or date of service	Not required*	Date of admission or date/s of service. If assignment to cover a course of treatment, include all dates of admission or dates of service	Date of admission or date/s of service. If assignment to cover a course of treatment, include all dates of admission or dates of service	Date of service, date of specimen collection (pathology services), or date of imaging procedure	Date of service, date of specimen collection (pathology services), or date of imaging procedure
Date of assignment	Not required*	Not required*	Not required*	The date the assignment form was completed.	The date the assignment form was completed.

Health professional/s covered by the assignment request	Not required*	Either: name/s 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: name/s of health professionals covered by the assignment OR a statement that the assignment covers all health professionals authorised to provide treatment to the patient	Name and details of the relevant health professional (including provider number and address). This is not required for pathology and diagnostic imaging services.	Name and details of the relevant health professional (including provider number and address). See Section 54 of the <i>Health Insurance Regulations 2018</i> .
Details of service	Not required*	Description of hospital treatment (with sufficient detail to cover all services for that episode of care, admission, or course of treatment, see Item 4.5 for example)	Description of hospital-substitute treatment (with sufficient detail to cover all services for that episode of care or course of treatment, see Item 4.5 for example)	Choose from the Basic Service Description categories. Download the list from MBS Online . For pathology and diagnostic imaging services, a description of the service sufficient to identify the MBS item is required (in alignment with referral descriptions).	Medicare benefits schedule item/s for assigned service
Who the benefit/s are assigned to	Not required*	Name of private health insurer OR approved billing agent. If assignment to cover multiple approved billing agents, include names of all billing agents and which service/s are to be assigned to them.	Name of private health insurer OR approved billing agent. If assignment to cover multiple approved billing agents, include names of all billing agents and which service/s are to be assigned to them.	Name and details of the relevant health professional. This is the same as 'Health professional covered by the assignment request'.	Name and details of the relevant health professional. This is the same as 'Health professional covered by the assignment request'.
Location where service/s are rendered	Not required*	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	Not required*	Not required*

<i>Pre-service assignment or post-service assignment</i>	Not required*	Not required*	Not required*	State the agreement conducted is an ‘episodic pre-agreement’.	State the agreement conducted is an ‘episodic post-agreement’.
<i>Is the assignor the patient</i>	Not required*	Not required*	Not required*	The assignor to state yes or no if they are also the patient	The assignor to state yes or no if they are also the patient
<i>Statement of assignor’s agreement</i>	Not required*	See proposed wording in Item 4.2	See proposed wording in Item 4.2	Required for pathology determinable services or R-type diagnostic imaging services that are not described in the Details of service	Required for pathology determinable services or R-type diagnostic imaging services that are not described in the Details of service
<i>Assignor’s approval</i>	Not required*	Required in writing	Required in writing	Required in writing	Required in writing

*Information is not required to be provided to the patient or assignor under AOB requirements. IFC guidelines may still apply as per medical and hospital providers’ IFC practices.

Appendix B – Notification requirements - information to be provided to the patient or assignor

Notification Element	Medicare benefits received by private health insurer	Medicare benefits received by approved billing agent
Name of who sends the notification	Name of private health insurer	Name of approved billing agent
Patient's details	Patient's details	Patient's details
Patient's PHI details	Name of patient's private health insurer, and the patient's membership number or PHI identifier	Name of patient's private health insurer, and the patient's membership number or PHI identifier
Medical provider details	Name of the professional/medical provider who rendered, or on whose behalf was rendered, the professional service	Name of the professional/medical provider who rendered, or on whose behalf was rendered, the professional service
Date of service	Date on which the professional service was rendered	Date on which the professional service was rendered
Details of the service	MBS item that specifies the professional service	MBS item that specifies the professional service
Amount of Medicare benefit paid	Amount of Medicare benefit that was assigned and received by the private health insurer on behalf of the patient or assignor	Amount of Medicare benefit that was assigned and received by the private health insurer on behalf of the patient or assignor

Appendix C – Simplified billing - Record-keeping requirements and retention periods

Record-keeping element	What must be kept	Who must keep the records	Retention day / period	Legislative source
General obligation to keep AOB records	Records sufficient to evidence that a valid assignment of Medicare benefit occurred where the benefit is paid to a private health insurer or an approved billing agent rather than the patient	Any party relying on the assignment (hospital, medical provider, organisation, insurer, approved billing agent)	7 years after the relevant record is created (see specific record types below)	AOB Act 2024 – enables regulatory record-keeping framework under the HI Act
Complying private health insurance policy	Records, or a copy, of a complying health insurance policy relevant to the assignment	The private health insurer or the approved billing agent	7 years after the day the policy ceases to be in force	AOB Regulations 2025 – record retention requirements
Requested assignment – written agreement	A copy (or electronic record) of the completed assignment request showing the assignor’s written agreement and prescribed particulars	• Hospital (hospital treatment) • Medical provider or organisation (hospital-substitute treatment)	7 years after the day the assignment request was made	AOB Regulations 2025 – Division 7A (Subdivision C)
Requested assignment – modifications	A copy of the modified assignment request and the assignor’s written approval of the modification	Entity responsible for the original assignment request (as above)	7 years after the day the assignment was modified	AOB Regulations 2025 – modification record-keeping
Implied assignment – qualifying arrangement	Records evidencing a qualifying arrangement between the insurer and the medical provider, hospital or organisation (e.g. insurer agreements, MPPAs)	• Private health insurer • Any party (medical provider, hospital, or organisation) relying on implied assignment	The latter of: 2 years after the agreement or arrangement ceases to be in force; or 2 years after the day on which the records were created	AOB Regulations 2025 – Subdivision C (implied assignment) and AOB Act 2024

Claims declaration evidence	Records supporting the assignment declaration made with each simplified billing claim, showing the declaration was true and supported by a valid assignment	The party (medical provider, hospital, or organisation) submitting the medical claim	7 years after the day the claim was made	AOB Regulations 2025 – claims declaration requirements
Authorisation to provide treatment for services	Records of the authorisation to render services that are provided as part of hospital or hospital-substitute treatment which are eligible for Medicare (75% benefit level of the schedule fee) and PHI benefits	• Hospital (hospital treatment) • Organisation (hospital-substitute treatment)	2 years after the day on which the records were created	AOB Regulations 2025 and AOB Act 2024