



Please fill in all fields below with your new details.

Complete this form using capital letter and black pen only.

The Personal Information collected on this form will be used in connection with the provision of medical treatment to Entitled Personnel (EP) and will otherwise be handled in accordance with the Medibank Health Solutions Privacy Policy which is available at medibankhealth.com.au

Provider ID/number:

AHPRA number:

Speciality (eg Orthopaedic surgeon):

Title: (Dr etc.) First Name: Last Name:

Practice name:

Address:

Suburb: State: Postcode

Provider's Phone Number: Provider's Fax Number:

Email address:

ABN:

GST: Are you registered for GST? Yes No

Person filling this form: First Name: Last Name:

Banking details

Bank name:

Account Holder Name:

BSB: Account number:

Have you signed a Garrison Health Services Provider Agreement? Yes No

Submit form to:

Garrison Health Services
C/- Medibank Health Solutions
PO Box 9999
MELBOURNE VIC 3001

Fax: **1300 633 227**

Email: ADFEquiries@medibank.com.au

Call: **1300 126 420**

Visit: medibankhealth.com.au/garrisonhealthservices