CBHS Health Fund Limited
ABN 87 087 648 717

Hospital Request for Direct Credit of Payments

Please complete and return to:

By post:
CBHS Health Fund Limited
Provider Relations
Locked Bag 5014
Parramatta NSW 2124

Fax: 02 9843 7677

Privacy collection statement

1. The information provided on this Form will be used by CBHS to make Hospital payments. It, together with the information in relation to the payments to be made, may be provided to CBHS's Financial Institution and to other people or bodies providing services to CBHS.

   If this information is not provided, CBHS will be unable to make the payments as requested.

Hospital details

2. **Please supply Hospital details**

Hospital Name

Provider Number

Address

State Postcode

Nominated account

3. **Please supply details of the account you want your credit payments made to**

Name of financial institution

Branch

Account name

BSB no. –

Account no.

Contact details

4. **Should we have any queries regarding this request or difficulties remitting payments to you, please provide a contact person.**

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname

Given names

Telephone ( )

Remittance advice details

5. **Please select the method you would like CBHS to use when advising you of payments made to the nominated account**

☐ Email

Email Address

Attention to

☐ Mail

Address

State Postcode

Attention to

Request and agreement

6. I request CBHS Health Fund Limited ('CBHS') to make payments for the Hospital named above, direct to the Nominated Account.

   In consideration of CBHS acting on this Request, I agree that:

   (a) a payment made to the Nominated Account will be regarded as having been made to the Hospital;

   (b) CBHS is not liable for any mistake or delay by my Financial Institution named above or for a payment properly made in accordance with this request;

   (c) CBHS will be given 14 days notice of any change to or cancellation of this request.

   I am duly authorised to make this Request and Agreement on behalf of the Hospital named above.

Name (please PRINT)

Signature

/ /

If you are authorised as an Attorney, Director or Officer, or in some other capacity, to make this request, please specify the Power of Attorney or the capacity in which you do so.