Pathology and Radiology Provider Registration & Change of Details Form

GMHBA HEALTH INSURANCE

☐ I would like to register with GMHBA (please complete the full form)

☐ I would like to update my details only (please complete your name and details to be updated)

Provider Details:

Provider name:

Provider numbers:

Specialty/s: Pathology and Radiology

Speciality code (if known)

Telephone number: Fax number:

Practice address: Postal address:

Email address:
(Please note that we can only reply to an ISP registered email address and not internet based email addresses such as yahoo or hotmail)

Direct Credit Payment Details:

Name of Financial Institution:

BSB Number: Account Number:

Contact Details:

Contact name (for account queries):

Contact Telephone:

Provider Consent:
GMHBA Limited seeks your content to be included in a GMHBA Provider List which will be made available via our website, an information brochure and health practice management software.

I give my consent to be included in a GMHBA Medical Gap provider list as follows:

Brochures:	Yes ☐	No ☐
GMHBA Website:	Yes ☐	No ☐
Health Practice Management Software:	Yes ☐	No ☐

Signed: Date: / /