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**MEDICAL PROVIDER DETAILS FORM**

**for Allianz Global Assistance OSHC & OVHC claims payments**

**Please return via email to the Medical Provider Management team at** **MedicalNetwork@allianz-assistance.com.au**

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| **PROVIDER / PRACTICE DETAILS** |
| **ABN:**  |  | **BUSINESS ENTITY TYPE:** E.g. Company, Trust, Sole Trader |  |
| **LEGAL ENTITY NAME:** |  |
| **PRACTICE NAME:** If different from above |  |
| **PRACTICE STREET ADDRESS:** |  |
| **PRACTICE EMAIL ADDRESS:** |  | **PHONE NO:** |  |
| **PRACTICE WEBSITE:** |  |
| **OPENING HOURS:**  | Monday |  | Friday |  |
| Tuesday |  | Saturday |  |
| Wednesday |  | Sunday |  |
| Thursday |  | Public Holidays |  |
| **MEDICAL SERVICES PROVIDED BY YOUR PRACTICE:**  |  |
| **PRIMARY CONTACT - Practice Manager or other primary contact. (Internal use only)** |
| **PRIMARY CONTACT NAME:** |  | **ROLE:** |  |
| **DIRECT EMAIL ADDRESS:**  |  | **PHONE NO:** |  |
| **ACCOUNTS DEPARTMENT** |
| **MAILING ADDRESS:** |  |
| **ACCOUNTS CONTACT PERSON:** |  |
| **REMITTANCE EMAIL:** |  | **ACCOUNTS PHONE NO:** |  |
| **EFT BANK DETAILS (Payments made by direct deposit only)** |
| Please submit one of the following as evidence of the bank account (must clearly show BSB, Account Number & Account Name):[ ]  **Bank Statement** (top section only required showing the account details) [ ]  **Bank Deposit Slip**[ ]  **Account Confirmation Letter** with bank letterhead [ ]  **Mobile banking site screenshot** |
| **BANK ACCOUNT NAME:** |  |
| **BSB:** |  | **ACCOUNT NUMBER:** |  |
| **BANK:** |  |

**Account submissions, claims & payment enquiries:** OSHCproviders@allianzcare.com.au 1800 884 526 Option 1, Option 2