

# HOSPITAL DIRECT CREDIT FORM

Please return the completed form by fax or email to:

**Fax:** (03) 9937 4419

**Email:** sprovsops@bupa.com.au

Should you require further information,  
please call Provider Operations on 1800 060 239

## SECTION A: Hospital details

Hospital name

Hospital address

Hospital provider number

Postcode

## SECTION B: Bank details

Name of Institution

Authorised name

Account holder's name

Title

Branch

Phone number

BSB number

Bank account number

Email

Signature

*Note: Please return with a bank deposit slip, cancelled cheque or bank statement to verify your account details.*

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## SECTION C: Direct credit authorisation

If there is more than one provider or signatory to the account, two signatures are required.

Authorised Signature

Date

Authorised Signature

Date

D D M M Y Y

D D M M Y Y