HOSPITAL DIRECT CREDIT FORM

Please return the completed form by fax or email to:
Fax: (03) 9937 4419
Email: sprovops@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

Phone number

Branch

Email

BSB number - Bank account number

Signature

D D M M Y Y

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

SECTION C: Direct credit authorisation

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

Authorised Signature

Date D D M M Y Y

Authorised Signature

Date D D M M Y Y