

Bupa Medical Gap Scheme Batch Header Form



When completing this form:

1. Please complete this form **USING BLACK INK** and write within the boxes in **CAPITAL LETTERS**.
2. Start at the left of each answer space and leave a gap between words. PLEASE DO NOT STAPLE.
3. Read the declaration and sign the signature panel below.

SECTION A: Please complete your practice details

Practice name

Practice ID

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SECTION B: Complete this form, attach all accounts and either post or email to:

Bupa
Medical Claims
GPO Box 2213
BRISBANE QLD 4001
GapScheme@bupa.com.au

Date

D	D	M	M	Y	Y
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Total number of claims

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Contact name

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Contact email

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Contact's phone number

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Note: You must include on each invoice both the Facility Number (ID) and Name where the service took place. Failure to provide this information will mean that we will reject your claim, requiring it to be re submitted with all information. For more information, go to www.bupa.com.au/for-providers

SECTION C: Declaration

This medical practice agrees to bill Bupa HI Pty Ltd (Bupa) directly for services attached and accepts the Bupa Medical Gap Scheme Terms and Conditions as supplied by Bupa.

Registered **No Gap** Providers who use the Medical Gap Scheme at eligible facilities accept the Bupa benefit as full payment for the episode of care, with no extra fees to the member.

Authorised name

Authorised signature

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Registered **Known Gap** Providers who use the Medical Gap Scheme at eligible facilities accept the Bupa benefit, and agree to charge a maximum Known Gap of up to \$500 over a whole episode of care.

The professional services specified on the attached forms were provided by me or on my behalf. These services were rendered as an inpatient of a hospital or approved day hospital facility.

Authorised position

Date

D	D	M	M	Y	Y
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SECTION D: Comments
