Australian Government
Medicare Australia

# Hospital/Day Procedure Centre (DPC) registration for In Hospital Claiming (IHC)

## Important information

This form is used to register a hospital to participate in ECLIPSE

**Assistance**
If you need assistance in completing this form call Medicare Australia on **1800 700 199**** or visit **www.medicareaustralia.gov.au**

**Lodgement**
Send completed and signed form to:

**eBusiness Service Centre**
**Medicare Australia**
**GPO Box 9822**
**in your capital city**
or fax to: the eBusiness Service Centre in your state:

| | | | |
|---|---|---|---|
| ACT/NSW: | **(02) 9895 3190** | VIC: | **(03) 9605 7981** |
| TAS: | **(03) 6215 5600** | SA/NT: | **(08) 8274 9408** |
| WA: | **(08) 9214 8173** | QLD: | **(07) 3004 5526** |

**Tick where applicable** ☑

## Administrative information about your organisation

1 Registered name of Health Sector Entity

2 Trading name of Health Sector Entity

3 Australian Business Number (ABN)

☐☐ – ☐☐☐ – ☐☐☐ – ☐☐☐

4 Permanent address

Postcode

5 Postal address (if different from above)

Postcode

6 Hospital/DPC facility ID

☐☐☐☐☐☐☐☐

## Location information

7 Location name

8 Location ID issued by Software Vendor

☐☐☐☐☐☐☐☐☐

9 eCertificate/Public Key Infrastructure (PKI)/Registration Authority (RA) number

☐☐☐☐☐☐☐☐☐☐

☐ Tick this box if the hospital does not have a location eCertificate/PKI/RA number.
If this box is ticked, the details on this form will be used to issue the Hospital with a Health Care Location eCertificate.

10 Anticipated implementation date

/ /

## Duly Authorised Officer's contact details

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

11 Family name

First given name

12 Position

13 Phone number

( )

Fax number

( )

Email

@

**Note:** If you wish to use your certificate for the purpose of secure email, a valid email address must be provided.

## Evidence of Identity

14 Provider number

or

☐ The Duly Authorised Officer has completed an Acceptable Referee Identification Form which is available at **www.medicareaustralia.gov.au** then go to **>providers>forms>registration**

** **Call charges apply from mobile and pay phones only.**

## Declaration

**I declare that**: I am the duly authorised officer to supply information on behalf of the hospital identified herein, and that all information provided on this form is true and correct.

I agree to inform Medicare Australia's eBusiness Service Centre of changes to the location ID, eCertificate RA number, or other relevant information.

15 Name of authorised officer

Signature of authorised officer

Date

/ /

## Medicare Australia use only

16 Verified by

Date

/ /

## Privacy note

The personal information provided on this form will be used to identify the details of the contact person nominated by the hospital registering to participate in ECLIPSE. This information may be disclosed to the Department of Health and Ageing and Department of Veterans' Affairs as well as relevant private health funds or as authorised or required by law.