



Notification of bank account details for an approved pharmacy

Purpose of this form

Complete this form to update or provide your banking details to the Australian Government Department of Health (Department) for payments made through claiming for the Pharmaceutical Benefits Scheme.

You will need to allow **10 working days** for the change to take effect.

For more information

Go to **www.health.gov.au/pbsapprovedsuppliers**. For assistance completing this form, email details of your enquiry to **pbsapprovedsuppliers@health.gov.au** and a departmental officer will contact you, or call **1800 316 389** (call charges may apply).

Returning your form

Check that all required questions are answered and the form is signed and dated.

This form, and any related attachments, must be lodged via the PBS Approved Suppliers Portal **PBSApprovedSuppliers.health.gov.au**.

Further information on how to lodge your form is available at **www.health.gov.au/pbsapprovedsuppliers** under Guides and Forms – *How to upload PDF forms or additional requested information.*

Please do **not** email your form as emailed forms may not be processed. Please do **not** email your form in addition to uploading it via the Portal as this adds to the processing time for all submissions.

Privacy and your personal information

Personal information is protected by law, including the *Privacy Act 1988*.

Personal information is being collected in this form by the Department for the purposes of processing your notification of an approved pharmacy's bank account details or changes to existing bank account details for the purposes of claiming for the Pharmaceutical Benefits Scheme.

If you do not provide this information, the Department will not be able to process your notification.

You can get more information about the way in which the Department will manage personal information, including our privacy policy, at **www.health.gov.au/pbsapprovedsuppliers/forms-privacy**.

Pharmacy details

1 Pharmacy business (trading) name

2 PBS approval number

3 Address of pharmacy premises

Postcode

4 Daytime phone number

Contact person's details

5 Dr Mr Ms Other

Family name

First given name

6 Daytime phone number

Email

Pharmacy bank account details

- 7** I would like to: **Tick ONE only**
Register new bank account details **Go to 9**
Change bank account details **Go to next question**
- 8** If notifying the Department of a change to bank account details, record the old bank account details below.
Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

- 9** The following account details are to be used, effective from
 / /
Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be the card number)

Account held in the name(s) of

- All payments are made through Electronic Funds Transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT deposits.

Declaration

This declaration must be signed by all business owner(s).

10 I/We authorise:

- payments to be made into the nominated bank account.

I/We declare that:

- I/we are authorised to provide details of the bank account.
- the information I/we have provided in this form is complete and correct.

I/We understand that:

- giving false or misleading information is a serious offence.

Business owner 1

Full name

Signature

Date

Business owner 2

Full name

Signature

Date

Business owner 3

Full name

Signature

Date

Business owner 4

Full name

Signature

Date



If there are more than 4 business owners, attach a separate sheet with details.