AusMed HEALTH
ABN: 71 643 436 177

**P:** (03) 9560 3168
**E:** contact@ausmedhealth.com.au

https://www.ausmedhealth.com.au/
6 Precision Lane, Notting Hill, VIC 3168

# BILLER AUTHORITY DEED

This Deed must be completed and submitted to AusMed Health by the Organisation responsible for paying the invoices. This Deed will enable the Client (or their representative) to place orders.

For NDIS customers, please email: **contact@ausmedhealth.com.au**

For Home Care Package and other funded customers, please email **contact@ausmedhealth.com.au**

**Please ensure all details are completed and correct before submitting for processing.**

| | |
|---|---|
| **Recipient Name (Client):** | |
| **Recipient Account Code: (if known)** | |
| **Recipient Address:** | |
| **Funding Type: (e.g. NDIS, HCP)** | |
| **Recipient Reference #: (eg. NDIS #, Claim #)** | |
| **Date of Birth: (mandatory for NDIS)** | |
| **Recipient Contact Number:** | |
| **Recipient Email Address:** | |
| | |
| **Biller Name: (Funding Manager)** | |
| **ABN:** | |
| **Biller Postal Address:** | |
| **Biller Email Address: (for invoices & statements)** | |
| **Biller Contact Name:** | |
| **Biller Contact Phone #:** | |
| **Funding Start Date:** | |
| **Funding End Date:** | |

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| | |
|---|---|
| **Expected Spend During Funding Period (for this client with AusMed Health):** | |
| **Other Notes:** | |

**The Provider:**

1. acknowledges that they will be liable for knowingly placing an order that exceeds the Recipient's funding balance or was aware/could foresee that the client's funding would be insufficient to meet the total cost of the order or the items ordered are not covered under the client's plan
2. is solely responsible for advising AusMed Health in writing if the client's fund is materially reduced or ceases.
3. has obtained the authority of their client to use and share the information to facilitate the fulfilment of orders.
   Our Privacy Policy can be found at
   https://www.ausmedhealth.com.au/pages/privacy-policy

**Signed as an Agreement for the Provider**

**Provider:** _____

**Name (print):** _____

**Business Title:** _____

**Date:** _____ / _____ / _____ **(DD/MM/YYYY)**