Australian Government
Department of Veterans' Affairs

Application for Provider Registration For an Orthoptist

IMPORTANT

This application for registration as a Repatriation Commission provider is an offer by me to be registered to provide health services on request to eligible veterans, war widow(er)s and their dependants.

The Department of Veterans' Affairs (DVA) requires the information on this form to assess your application for registration as a DVA provider in accordance with the *Veterans' Entitlements Act 1986*. If your application is approved, all information necessary will be disclosed to Medicare Australia which pays claims on behalf of DVA. In the event of inappropriate servicing or treatment, or unprofessional conduct, relevant information relating to the standard and/or level of treatment provided may be disclosed to the relevant State Government or Territory Registration Board or Professional Body.

ENQUIRIES • Telephone: **1800 550 457** • Email: **regqueries@dva.gov.au**

PLEASE
- use BLOCK letters *OR* complete on screen, save and print
- read any additional documentation provided
- remember to sign and date the application.

1. Provider Details

Provider number *(if applicable)*

Preferred title

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐

Other ☐ ▶ Please specify

Surname

Given names

Business name

Practice location address linked to your provider number
(if different to your mailing address - a post office box number is not acceptable - refer to Section 5) *(incl postcode)*

Telephone number *(incl area code)*

Mobile number

Fax number *(incl area code)*

Email address

2. Professional Qualifications

Initial professional qualification

Qualified at

Year qualified

Other qualifications or speciality

State/Territory registration no. *(if applicable)*

Date first registered

3. National Professional Association Details

Are you a current member of a national professional association *(if applicable)***?**

No ☐ ▶ Are you eligible for full membership of a national professional association?

No ☐ Yes ☐

Yes ☐ ▶ Please provide the following details

Name of association

Type of membership *(if applicable)*

Membership number (if applicable)

Are you an accredited/certified practising provider ?
(if applicable to your membership)

No ☐ Yes ☐

4. Practice, Payment and Notification Addresses *(if different from your address in Section 2.)*

Payment for services rendered can be made to:

- your practice address;
- your private address;
- your trading/company name and address;
- your agency or group practice.

If there is insufficient space please attach a separate sheet with the appropriate information. Also supply provider numbers for all practices.
A notification address is required for the service of Notices as per the Terms and Conditions of the Deed of Agreement/Contract.

Mailing address *(for receipt of payments and correspondence)* **and contact number if different to Section 2** *(incl postcode)*

Provider Number

Telephone number *(incl area code)*

Fax number *(incl area code)*

Email address

Group link number

5. Taxation Status

Are you defined in the tax legislation as:

a local governing body?

No ☐ Yes ☐

a supplier not carrying on an enterprise?

No ☐ Yes ☐

an income tax exempt organisation?

No ☐ Yes ☐ ▶ please attach evidence of your tax-exempt status

6. Australian Business Number (ABN Details)

DVA requires all providers to have an ABN

Do you or your business entity have an ABN?

attach a list of ABNs relevant to your practice locations

No ☐ Yes ☐ ▶ Please provide the following details

ABN *(11 digit number)*

ABN Branch registration number *(if applicable) (3 digit number)*

Business/Trading name *(under which the ABN is registered)*

Date of effect of ABN registration

7. GST Registration Details

Are you registered for GST?

No ☐ ▶ Are you engaged by your own business entity that is registered for GST?

No ☐

Yes ☐ ▶ Date of effect of GST registration *(as advised by ATO)*

Yes ☐ Date of effect of GST registration *(as advised by ATO)* ▶

8. Recipient Created Tax Invoice (RCTI) Details

Providers who are registered for GST are required to enter into an RCTI Agreement with DVA

Please complete **two** copies of the RCTI Agreement and return both copies to DVA. DVA will sign both copies, retain one and return the other copy to you for your records. Please refer to the attached RCTI Instructions and complete the RCTI Agreement.

9. Professional Practice

Have you previously been a DVA Provider or a DVA Provider at a different practice location?

No ☐

Yes ☐ ▶ Please provide the following details

Provider number

Year commenced

Year ceased

State

Have any limitations been imposed on your ability to practice or prescribe?

No ☐ Yes ☐ ▶ Please provide details

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10. Insurance Requirements

DVA requires providers to meet the following insurance requirements:

- Public Liability Insurance ($10 million per claim);
- Professional Indemnity Insurance ($5 million per claim);
- Appropriate Disability Income Protection Insurance or Worker's Compensation Cover.

Do you have current insurance to meet the above requirements?

No ☐ Yes ☐

11. EFT Banking Details

I, the applicant, being a practitioner entitled to render professional services, apply to the Department ofVeterans'Affairs to have DVA benefits paid directly into the account below.

Name of bank, building society or credit union

Type of account (e.g. savings, cheque)

Branch

Branch number (BSB) (6 digit number)

Account number (9 digit number)

Account held in the name of

12. Certification and Conditions *(if applicable)*

Completion of this form does not mean automatic registration as a DVA Provider. The conditions relating to the provision of health services to entitled veterans and their dependants, and the terms of the contract with the Repatriation Commission are set out in the Notes/Deed of Agreement/Contract and its Schedule(s).

If my application for registration is accepted, I agree to the terms and conditions in the Deed of Agreement/Contract.

I am aware that giving false or misleading information is a serious offence.

I certify that all information I have given in this form and contained in any attachments is true and correct.

Applicant's signature

/ /

Printed name

13. Checklist

Before sending your application please ensure that you have:

☐ Read and completed **Section 12 - Certification and Conditions** *(if applicable)* of this form.

☐ Signed and dated the form.

☐ Attached a copy of your current practising certificate *(if applicable)*.

☐ Attached copies of relevant qualifications to support your application.

☐ Attached a copy of your X-Ray equipment licence *(if applicable)*.

☐ Attached references detailing your experience.

☐ Attached two signed original copies of the RCTI Agreement.

14. Lodging your application

Please mail your completed application to:

Provider Registration Officer
Department of Veterans' Affairs
MALCM
PO BOX 9998
Canberra ACT 2601

Or facsimile your completed application to:

02 6289 6764

Thank you for completing this form.

Print Clear Save

OFFICE USE ONLY

Provider No. ..... Provider Type. .....

Speciality Code(s) .....

Commencement date of contract ...../...../.....

Name of DVA Authorising Officer (BLOCK letters) .....

Signature .....