Hospital authority to add or change payment details

Please note: It is your responsibility to ensure that all your bank and address details are kept up to date with nib.
Use this form to advise nib health funds to pay benefits by Electronic Funds Transfer (EFT) to a nominated bank account.

Part 1 – Provider details

Provider name

Provider number

Part 2 – Account details

☐ I authorise nib health funds to directly transfer payments via EFT into the account nominated below.

Name of bank/financial institution

Address of bank/financial institution

Suburb State Please select Postcode

BSB number

Account number

Name on the account

Do the above details relate to any additional provider numbers?

Yes ☐ No ☐

If yes, please list ALL additional provider numbers these bank details will apply to (if applicable)

Date this payment detail change/addition is to take effect

Part 3 – Authorisation

Contact phone number

Name

Title

Provider's signature

Date

☐ I hereby consent to nib health funds informing that I am an authorised representative of the provider.

Need help?

Call: **1300 853 530**

Email: **providers@nib.com.au**