nib
Health Funds Limited
A.B.N. 83 000 124 381

Application for Online Optical Dispenser Provider Recognition

The form **must** be read in conjunction with the ‘nib Provider Guidelines, Terms and Conditions’ document as provided to you with this form. The declaration at the end of this form states that you have read, understood and agree to the conditions set out in this document. Do not submit the form if you have not read the accompanying document.

Business Information

Full Business Name		**Date Established**
Business Address		
Contact Phone ( )	**Fax** ( )	**ABN**
Postal Address		
Email address		

Is your company based in Australia? ☐ Yes ☐ No

Is the physical location listed above recorded on all invoices/receipts issued? ☐ Yes ☐ No

Please list the location/s from where your products are shipped (i.e. warehouse address).

How do you verify the customer's optical prescription? And how often is this verification performed?

Do you decline to fill an order where the optical prescription is older than two years? ☐ Yes ☐ No

For Prescription glasses how do you obtain the customers facial measurements and fit the appliance?

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Business Information

How do you determine if the customer that is paying for the services and being invoiced is actually the person that the optical appliance or contacts is for?

Do you fully itemise invoices? ☐ **Yes** ☐ **No**
(including clear description of products such as sunglasses, tinting, protective coating etc)

Do you ensure the customer is aware of contact lens hygiene? ☐ **Yes** ☐ **No**

If yes, then how?

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Do you ensure the customer is aware of how to insert and remove contact lenses correctly and safely? ☐ **Yes** ☐ **No**

If yes then how?

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Declaration – all providers

- I declare that I have read, understood and agree to the 'nib Provider Requirements, Terms and Conditions' document, as provided to me by nib. I agree to adhere to ALL guidelines and rules in the document, including those relating to patient record and accounts/receipting standards.
- I acknowledge that nib provider recognition can be suspended or withdrawn at any time without question or prior notice, for breach of professional conduct and/or breach of nib Provider Guidelines, Terms and Conditions – in nib's total discretion.
- I understand that the lodgement of this application does not signify automatic recognition by nib as a service provider.
- I declare that the above details recorded by me are true and correct.
- I authorise nib to obtain further information about my application from other organisations as deemed necessary to assess my request for recognition.

Full Name	
Signature	**X**
Address	
Suburb/Town	
State	
Postcode	
Date	

To submit your application, please mail or email to:

Ancillary Provider Management
nib health funds
22 Honeysuckle Drive
Newcastle NSW 2300

providers@nib.com.au

For further information please call:

Provider Relations at nib on **1800 175 377**