



# Direct Credit Payment Details Form

**GMHBA Limited** ABN 98004 417 092  
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Web: [GMHBA.com.au](http://GMHBA.com.au)

Unless account numbers are the same for all provider numbers,  
please complete a separate form for each provider.

Provider name: .....

Provider number(s): .....

.....

Direct credit payment details required:

Name of institution: .....

Location of institution: .....

Account name: .....

BSB number:    -

Account number:

Signature: .....

Date: ...../...../.....

Please return completed form to:

**Hospital Episodes Team  
GMHBA Limited  
PO Box 761  
GEELONG VIC 3220**

Thanks you for participating in GMHBA's Medical Gap product.