Provider Recognition Application
Orthotists and Medical Grade Footwear Manufacturers

Providers must complete this application form and meet all the provider recognition criteria to be considered for 'recognised provider' status with Health Partners. Please refer to the Health Partners 'General Treatment Provider Recognition Policy' available online prior to submitting your application.

Provider details Please list private practice details only *(Health Partners does not recognise services provided in a public or community setting).*

Primary Practice Information

Practice/Trading name ABN

Address Postcode

Phone Fax

Mobile Date you started practicing at this location / /

Email Website

Addtional Practice

Practice/Trading name ABN

Address Postcode

Phone Mobile Fax

For further additional practices, please list details on a separate sheet and attach to this form.
Important: Please attach a sample of official invoice and receipt stationery for each practice location.

Practitioner's Details

Title ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Dr ☐ Other *(please specify)*

Name *(first name)* *(surname)*

Are you an Australian citizen or permanent resident? ☐ Yes ☐ No

Do you hold current Professional Indemnity Insurance *(minimum value $1,000,000 per claim)*? ☐ Yes (*evidence required)* ☐ No *(if no, recognition may not be granted)*

Do you hold a current Senior First Aid certificate or equivalent? ☐ Yes (*evidence required)* ☐ No *(if no, recognition may not be granted)*

Professional Membership and Provider Recognition

Do you hold any current membership/registration with any professional association or registration board?
Please also include any relevant memberships/registrations for your staff ☐ Yes ☐ No

If yes, please provide details, including the name of the organisation below.

Member name	Name of Board or Association	Membership level	Membership number	Date of membership registration

For additional memberships, please list details on a separate sheet and attach to this form. Please provide certified copies of membership and/or registration documents for each Board or Association you are currently registered with.

Has your membership or registration with any professional body, health fund or association been cancelled, suspended or withdrawn for any reason? ☐ Yes ☐ No

If yes, please provide details, including the name of the organisation below:

Professional qualifications and training

Please list the educational qualifications you hold and include any relevant qualifications for your staff.

(Note: Health Partners will only accept qualifications gained from an accredited Australian College or University).

Name	Year awarded	Title of award	Course duration	Name of institution

Please provide certified copies of official documentation proving completion of studies for each of the educational qualifications listed above.

Do you have Provider Recognition with other health funds? ☐ Yes ☐ No

If yes, please provide details.

Fund name	Provider number

Referrals and modifications

Please provide details of the range of custom-made shoes, modifications to shoes and orthotics you supply.

Please list the type of professionals from whom you receive referrals.

What information do you require on a professional referral?

Please attach sample referral if possible.

Do you agree to provide copies of referrals to assist with assessment of member benefits, as requested by Health Partners staff?
(Failure to provide referrals on request may result in the suspension or cancellation of your Provider Recognition). ☐ Yes ☐ No

Preferred option to provide referral copies ☐ Fax ☐ Mail ☐ Email

Are the orthotics, custom-made shoes or modifications to shoes performed on the premises? ☐ Yes ☐ No

If no, please provide details of who provides these services.

Following provision of the shoes/orthotics, what follow-up process is used by the referring professionals in order to determine if the fitting is correct?

Application checklist

Copies of the documentation listed below must be included with your application. All copies must be certified by a Justice of the Peace or a qualified witness^ (Refer below) for declarations in the relevant state or territory.

- ☐ Photo identification (e.g.current driver's licence, passport, proof of age or similar)
- ☐ Proof of current professional liability insurance valued at $1,000,000 or over, displaying expiry date
- ☐ Proof of current Senior First Aid certification or equivalent, displaying expiry date
- ☐ Proof of membership/registration with Professional Bodies
- ☐ Proof of educational qualifications
- ☐ Copy of letters from other health funds confirming your provider recognition status
- ☐ Copy of your official invoice and receipt stationery for each practice location.

Declaration *Please tick*

- ☐ I declare that I have read, understood and agree to the Health Partners General Treatment Provider Recognition Policy document, available on the Health Partners website.
- ☐ I agree to adhere to all guidelines and rules in the above mentioned Provider Recognition Policy, including those relating to patient records and accounts/ receipt standards.
- ☐ I understand that the lodgement of this application does not signify automatic recognition by Health Partners as a service provider.
- ☐ I acknowledge that Health Partners may immediately suspend or withdraw my provider recognition at any time without prior discussion or notice, should there be evidence of any professional misconduct, and/or breach of 'Health Partners General Treatment Provider Recognition Policy' and/or fraud, whether proven or reasonably suspected.
- ☐ I declare that all details recorded by me within this application are true and correct.
- ☐ I authorise Health Partners to obtain further information about my application from other organisations as deemed necessary to assess my request for recognition.

Applicant details	**Witness^**
Full name	Full name
Address	Address
Postcode	Postcode
Signature	Signature
Date / /	Date / /
	JP number

For further information contact Health Partners on 1300 113 113 or email ask@healthpartners.com.au.

Once completed, please email your application to the Health Partners Provider Operations team on providers_dl@healthpartners.com.au, or post to Health Partners, Reply Paid 1493, Adelaide SA 5001.

^Witnesses may be one of the following:

South Australia – Justice of the Peace, Proclaimed (bank) Manager, Proclaimed Police Officer or a Notary Public. Northern Territory – Any person over the age of 18 years.

Queensland – Justice of the Peace, Commissioner for Declarations, Notary Public, Solicitor or Barrister.

Victoria – Justice of the Peace or Bail Justice, Notary Public, Barrister and Solicitor of the Supreme Court or a member of the Police Force.

Tasmania and Western Australia – Justice of the Peace, Commissioner for Declarations, Members of Professional Occupational (e.g. Doctor, Lawyer, Police Officer). Australian Capital Territory – Justice of the Peace, Members of Professional Occupations (e.g. Doctor, Lawyer, Police Officer, Teacher).

New South Wales – Justice of the Peace, Notary Public, Commissioner of the Court for taking Affidavit, legal practitioner or other person by law authorised to administer an oath.