Australian Government

Department of Health

Authority to authorise pharmacist(s) to sign claim forms on behalf of a hospital authority

Purpose of this form

Complete this form to:

- authorise a pharmacist(s) to sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on behalf of a hospital authority; and/or
- request removal of previously authorised pharmacist(s).

For more information

Go to **www.health.gov.au/pbsapprovedsuppliers**.
For assistance completing this form, call **02 6289 2419** (call charges may apply) or email **pbsapprovedsuppliers@health.gov.au** and a departmental officer will contact you.

Returning your form

Check that all required questions are answered and that the form is signed and dated.

This authority form must be lodged through the Health Data Portal **dataportal.health.gov.au**.

For further information on how to lodge your form visit **www.health.gov.au/pbsapprovedsuppliers**. Please do **not** email your form as emailed forms may not be processed.

Privacy and your personal information

Personal information is protected by law, including the *Privacy Act 1988.*

Personal information is being collected in this form by the Australian Government Department of Health (the Department) for the purposes of processing your authorisation for specified pharmacist(s) to sign pharmaceutical benefit claim forms and endorse pharmaceutical benefit prescriptions on behalf of a hospital authority; and/or your request for removal of a previously authorised pharmacist(s).

If you do not provide this information, the Department will not be able to process your authorisation and/or request.

You can get more information about the way in which the Department will manage personal information, including our privacy policy, at **www.health.gov.au/pbsapprovedsuppliers/forms-privacy**.

Hospital details

1 Hospital authority name

2 PBS approval number (if known)

3 Hospital name

4 Hospital address

Postcode

Authorised pharmacist(s)

5 Give details of all authorised pharmacists

Authorised pharmacist 1

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Registration number

P H A

Signature

Authorised pharmacist 2

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Registration number

P H A

Signature

Authorised pharmacist 3

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Registration number

P H A

Signature

Authorised pharmacist 4

Dr ☐ Mr ☐ Ms ☐ Other

Family name

First given name

Registration number

P H A

Signature

If there are more than 4 authorised pharmacists attach a separate sheet with details.

Previously authorised pharmacist(s)

6 Please list here any previously authorised pharmacists you want to cancel

Authorised pharmacist name

Authorised pharmacist name

Authorised pharmacist name

Authorised pharmacist name

If there are more than 4 previously authorised pharmacists attach a separate sheet with details.

Declaration

7 **I declare that**:

- the information I have provided in this form is complete and correct.
- I am authorised to sign this form on behalf of the hospital authority.

I understand that:

- giving false or misleading information is a serious offence.

I authorise the pharmacist(s) whose signature(s) appear in question 5, to:

- sign pharmaceutical benefit claim forms.
- endorse pharmaceutical benefit prescriptions on behalf of the hospital authority.

Name

Signature

Date / /

Position held

Contact phone number

Clear form Print form