Centre for Eye Health

Registered Practitioner Change of Details form

Fax to 02 8115 0799 or Email to enquiries@cfeh.com.au

PRACTITIONER DETAILS

Profession: _____ **Medicare Provider *:** _____

Title: _____ **First name:** _____ **Surname:** _____

Mobile #: _____

ADD AN ADDITIONAL PRACTICE NOW MY PRIMARY PRACTICE Y/N

Practice Name: _____ **Medicare Provider *:** _____

Mail Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Email: _____ **Practice Phone:** _____

REMOVE MY LISTING FROM A PRACTICE

Practice Name: _____

Medicare Provider Number*: _____

UPDATE MY DETAILS

(For Correspondence Other Than Reports)

Yes I would like to receive updates via ☐Email or ☐Post ☐No I do not want to receive updates

Email: _____

Postal Address: _____

AGREEMENT

I confirm that the information I have provided above is correct.

Signature: _____ Date: ☐☐/☐☐/☐☐☐☐

*For use by CFEH for internal unique identification purposes only.

CFEH Office Use Only

Date received: _____ VIP ❑ DR ❑ PACK ❑ SCAN ❑ Initial Registration :_____