To: AGD MBS Administrator

MEDICAL BILLING SYSTEM APPLICATION FORM

MBS@Gov is a digital service for private clinics and dialysis centres to submit claims for the government's share of medical bills incurred by civil servants, pensioners and their dependants. Participating clinics will receive a consolidated payment on a weekly basis via Inter-Bank GIRO into the designated bank accounts.

Please complete this form to register with MBS@Gov.

You may mail the completed form and a copy of the clinic's **MOH Licence** to the following address at:

Accountant-General's Department
100 High Street
#06-01 The Treasury
Singapore 179434

We thank you for your support towards MBS@Gov.

Please note that clinics are required to have a CorpPass account to login to MBS@Gov.
You may refer to the CorpPass manual on MBS@Gov homepage for more information.

Section A

MOH Licence Number	
MOH Healthcare Institution (HCI) Code* *Note: The HCI Code will be your Vendor ID for MBS@Gov.*	
Clinic Unique Entity Number (UEN)	
Clinic Name	
Clinic Address/ Stamp	
Approved by Clinic Manager	
Name of Clinic Manager	
E-mail Address of Clinic Manager	
Signature & Date	

*You may refer to http://hcidirectory.sg/ for the clinic's Healthcare Institution code.

Section B [*For Use by AGD MBS Administrator*]

Processed by / Date processed	

APPLICATION FORM FOR MEDICAL BILLING SYSTEM
(DIRECT CREDIT AUTHORISATION)

This form may take you 10 minutes to fill in.
You will need the following information to fill in the form:

- **The Private Medical Practitioner's (PMP) registration number (i.e. MOH License no., ACRA no., NRIC no., OR FIN No.)**
- **The PMP's bank account details**

INSTRUCTIONS TO FILL IN THE APPLICATION FORM

(A) Important Points to Note to Ensure Prompt Payments:

(i) This form is used for **new PMP** who wishes to participate in the Medical Billing Scheme and to receive payment for the government co-payment by direct credit into the designated bank account as well as for **existing PMP** who wishes to change their existing details, such as bank account information, contact number, fax number or email.

(ii) Please fill in Part I of the form and get your bank's endorsement in Part II.

(iii) Mail the completed form to:

Accountant-General's Department
100 High Street
#06-01 The Treasury
Singapore 179434

(B) General Information

For a Company, Business or Limited Liability Partnership registered with ACRA, you can obtain your ACRA registration number **and** ACRA registered name via ACRA website (www.acra.gov.sg). Select *Quick Links/Directory Search/Registered Business Entities* then enter your ACRA registration number or ACRA registered name.

APPLICATION FORM FOR MEDICAL BILLING SYSTEM (DIRECT CREDIT AUTHORISATION)

Note: No correction tape/fluid should be used on this form. Any cancellations made must be endorsed by the supplier/bank.

Please tick one of the relevant boxes:
Application for new MBS@Gov user ☐ Update for existing MBS@Gov user ☐

Part I (TO BE COMPLETED BY PRIVATE MEDICAL PRACTITIONER WHO PARTICIPATES IN THE MEDICAL BILLING SCHEME)

To: ACCOUNTANT-GENERAL

1. CLINIC INFORMATION

ACRA No. (if applicable)	
Name of Register doctor*	
Clinic Name *	
Clinic Address*	

MOH License No.*	
Telephone No. *	
Fax No.	
Email Address *	(Note: Remittance Advice will be sent to the email address given)
GST Registered *	Yes / No GST No.:

2. BANK ACCOUNT DETAILS

Name(s) of Bank Account Holder(s) *

Bank No *	Branch No *	Bank Account No to be Credited*

Bank and Branch Name *

(a) I/We hereby authorise the Government and Statutory Boards to credit payments due to me/us to the above account. Amounts so credited would constitute valid discharge of obligations due to me/us.
(b) This authorisation shall continue to be in force until I/we have notified you in writing.
(c) I/We hereby request and authorise the Government and Statutory Boards to obtain confirmation/verification of information relating to me/us and/or to my/our account(s) from/with the bank where the Account is maintained as stated in the form.
(d) In consideration of the Government and Statutory Boards acceding to my/our said request and in consideration the Bank confirming/verifying such information pursuant to the said request, I/we irrevocably consent to and authorise the Bank, including any officer thereof, to disclose any information whatsoever relating to me/us and to the Account as is necessary for the sole purpose of account validation and agree that such authorisation shall survive any termination of the Account. I/We agree that this consent shall survive the termination of any of the Account with the Bank and may be relied on and enforced as fully and effectively by the Bank as if it is addressed to the Bank.
(e) I hereby consent to the release of my updated address by the Immigration and Checkpoints Authority (ICA) to the Accountant-General's Department for the purpose of sending the Remittance Advice to me.

Authorised Signature(s) and stamp as in bank's record _____ Date

Part II (FOR PRIVATE MEDICAL PRACTITIONER TO GET BANK ENDORSEMENT)

To: ACCOUNTANT-GENERAL
We hereby certify that the signature(s) and other particulars as stated in Part I agree with that contained in our records.

Name & Signature of Authorised Bank Officer _____ Date & Bank's Official Stamp