



Consultation on Assignment of Benefits for Simplified Billing – Regulations and System Changes

February 2025

[Introduction](#)

The Department of Health and Aged Care is modernising and simplifying the assignment of benefit process by creating solutions that will streamline Medicare billing for bulk billed and simplified billing services. The [Health Insurance Legislation Amendment \(Assignment of Medicare Benefits\) Act 2024](#) (AOB Act), which was passed by Parliament on 2 July 2024, with Royal Assent provided on 9 July 2024, provides the basis for this work. The changes enabled by the amended legislation will commence on 9 January 2026, unless proclaimed earlier.

This paper sets out specific amendments to [Health Insurance Act 1973](#) (HI Act) which require subordinate regulations and system changes to facilitate the new assignment of Medicare benefit requirements for simplified billing services. Any changes to regulations or systems are intended to commence at the same time as the amendments to the HI Act.

Stakeholders are invited to provide feedback on the proposed changes to:

- regulations ([Health Insurance Regulations 2018](#) (HI Regulations 2018)); and
- digital systems (Services Australia web services and claiming channels).

This paper focuses on simplified billing changes to assignment of Medicare benefits to a registered private health insurer ('private health insurer' or 'insurer') or an approved billing agent ('billing agent') only. For more information on the changes to assignment of benefits for bulk billed services, visit the [Improving the assignment of benefit process](#) webpage.

Assignment of Medicare benefits and simplified billing

Through the HI Act, the Australian Government subsidises the cost of health services by providing Medicare benefits to be paid directly to the patient. For Medicare benefits to be paid to another individual or organisation (such as a medical practitioner or private health insurer), the HI Act sets out a process for the eligible person (often the patient or another eligible person) to assign their right to payment of the Medicare benefit to a private health insurer, billing agent, or another person. This assignment process is a key aspect of simplified billing.

Simplified billing intends to reduce the number of accounts a patient receives for their hospital or hospital-substitute treatment and removes the need for a patient to pay the medical practitioner directly then claim for Medicare and private health benefits. Instead, hospitals, medical practitioners, and billing agents can make an electronic or manual claim through Services Australia channels to Medicare and the registered private health insurer. Assigned Medicare benefits are paid to the billing agent or a private health insurer who then processes it to the final beneficiary (i.e., medical practitioners or hospitals).

For services claimed through simplified billing, s20A(2A) of the HI Act currently sets out the requirements for an 'approved form' to enable a patient to make a valid assignment to an insurer or billing agent. Although current processes result in the Medicare benefit still being paid to the medical practitioner or hospital entitled to the benefit, there is no 'approved form' that facilitates a valid assignment. Changes to

assignment of Medicare benefit processes address these legal and compliance risks by using technology to improve compliance with payment integrity requirements and by streamlining assignment processes.

Based on ongoing stakeholder engagement and feedback received during the [December 2023 and April 2024 consultations](#), the department acknowledges that there are existing arrangements and practices that can be amended to facilitate new assignment processes. The intent of the AOB Act and proposed changes to regulations and system changes is to support the integrity of Medicare payments whilst modernising the assignment process between patients and either an insurer or a billing agent. To reduce significant system and process impacts, the changes leverage off the current practices set out in Table 1 and the existing arrangements listed below:

- an insurer and an eligible person through a complying private health insurance policy (CHIP)
- an insurer and medical practitioners for hospital and hospital-substitute medical services (e.g., medical gap cover arrangements)
- an insurer and hospitals/organisations for hospital and hospital-substitute medical services (e.g., contracting arrangements)
- hospitals and medical practitioners (e.g., private practice agreements)
- an eligible person and the medical practitioner or hospital through the informed financial consent (IFC) process

Table 1. General overview of current practice and patient journey for hospital treatment services claimed through simplified billing.

	Existing Arrangements	Informed Financial Consent Process			Services	Claims Submission	Claims and Benefits Processing		After Benefit Payment
		Initial Discussion with Practitioner (Surgeon)	Pre-Admission and Eligibility Check Processes						
Patient	Has a CHIP with an insurer	Agrees to treatment and associated costs (including paying 'out of pocket' costs)	Agrees to treatment and associated costs (including paying 'out of pocket' costs)	Elects to be treated as a private patient	Receives services				Receives statement of benefits from insurer and/or billing agent
Medical Practitioner	Has a medical gap cover arrangement with the insurer	Surgeon discusses cost of treatment and 'out of pocket' costs with patient	Conducts an eligibility check with Medicare and the insurer through Services Australia OEC services	Practitioner (e.g., anaesthetist) discusses costs of treatment with patient					
Hospital	Has a contract with the insurer		Conducts an eligibility check through Services Australia OEC services for Medicare and insurer coverage	Discusses costs of treatment and admission forms (e.g., patient election) with patient	Renders services	Submits relevant claims for payment to Medicare or the insurer		Receives Medicare and PHI benefits from the insurer	
Organisation	Has a contract with the insurer		Discusses costs of treatment with patient						
Insurer	Has arrangements with the patient, practitioner, hospital, or organisation		Sends information back to the practitioner, hospital or organisation via Service Australia OEC services regarding the patient's CHIP coverage and benefits for the service			Processes manual claims to Medicare for Medicare benefit	Assesses ECLIPSE claims	Pays the practitioner, hospital, or organisation the Medicare and PHI benefits	Provides patient with statement of benefits
Billing Agent						Submits relevant claims for payment to Medicare	Submits Statement of Medicare benefits to insurer for PHI benefits	Receives and manages Medicare and PHI benefits	

Changes to the Health Insurance Act 1973

In recognition of these arrangements and current practices, the AOB Act removes the requirement for an 'approved form' and allows for such arrangements to facilitate an assignment of Medicare benefits.

From January 2026, the basic rule for the assignment of Medicare benefits for simplified billing services under the new s20A(2) of the HI Act allows for the assignor (who is the 'eligible person' or 'the patient' to whom the Medicare benefit is originally payable to) to have assigned the Medicare benefit if the following key requirements are satisfied:

- under s20A(2)(a) – the service is provided to the patient as hospital or hospital-substitute treatment; and
- under s20A(2)(b) – the assignor has a CHIP with a private health insurer; and
- under s20A(2)(c) – the CHIP provides full or partial coverage for the service; and
- under s20A(2)(d) – a valid Medicare claim is made for the service to which the patient is eligible; and
- under s20A(2)(e), either:
 - the insurer has an existing arrangement with the medical practitioner, hospital or organisation with regards to fees and charges for the service, or
 - if there is no arrangement, the assignor has requested to assign their benefit to the insurer or billing agent via the medical practitioner, hospital or organisation.

To support the key requirements above, additional changes to simplified billing assignments are:

- The assignment must be recorded in writing.
- Improving eligibility checking and informed financial consent processes to support assignment of benefit requirements.
- To ensure accountability in the absence of an 'approved form', insurers, medical practitioners, hospitals, billing agents, and any relevant party will be required to keep records that evidence* the assignment or notification.
- A declaration that the assignment requirements have been satisfied will be part of the claim for that service.
- The insurer or billing agent is required to provide notification to the assignor within 6 months of receipt of the Medicare benefit.

*Records will not be required to be submitted with the claim. However, to ensure the integrity of Medicare payments, Services Australia and the department may request documentation to validate an assigned benefit and ensure that the requirements have been satisfied (e.g., evidence of notification).

Table 2 summarises changes to current practice for medical practitioners, hospitals, insurers, and billing agents and Table 3 sets out specific AOB Act amendments and detailed information on the changes.

Table 2. Requirements for simplified billing assignment of Medicare benefits from January 2026

Pathway [#]	Context	Who is making the claim		Private Health Insurer or Billing Agent
		Medical practitioner	Hospital/Organisation	
Implied Assignment Pathway – new s20AAA(1) and s20AAA(5) of HI Act and subordinate regulations	Medical practitioner, hospital, or organisation has an arrangement with the insurer and service is claimed through that arrangement	<p>Will need to attest as part of the claim that they have satisfied the requirements of legislation as it relates to the assignment of benefit</p> <p>Will need to retain records for a specified period relating to the rendered service and service as modified, and the arrangement with the insurer</p>	<p>Will need to attest as part of the claim that they have satisfied the requirements of legislation as it relates to the assignment of benefit</p> <p>Will need to retain records for a specified period relating to the rendered service and service as modified, and the arrangement with the insurer</p>	<p>Will need to send notification to the assignor within 6 months of the Medicare benefit being received</p> <p>Will need to retain records of relevant documents for a specified period</p>
Request Pathway – new s20AAA(3) and s20AAA(5) of HI Act and subordinate regulations	<p>Medical practitioner, hospital, or organisation has an arrangement with the insurer but service is <u>not</u> claimed through that arrangement</p> <p>OR</p> <p>Medical practitioner, hospital, or organisation does not have an arrangement with the insurer</p>	<p>Medical practitioner needs to facilitate the request for the assignor assigning their Medicare benefit to the insurer or billing agent</p> <p>If required, the medical practitioner needs to modify the request to cover complications or unplanned treatment</p> <p>Will need to attest as part of the claim that they have satisfied the requirements of legislation as it relates to the assignment of benefit</p> <p>Will need to retain records relevant to the assignment (e.g., the request and request as modified)</p>	<p>Hospital needs to facilitate the request for the assignor assigning their Medicare benefit to the insurer or billing agent</p> <p>If required, the hospital needs to modify the request to cover complications or unplanned treatment</p> <p>Will need to attest as part of the claim that they have satisfied the requirements of legislation as it relates to the assignment of benefit</p> <p>Will need to retain records relevant to the assignment (e.g., the request and request as modified)</p>	<p>Will need to send notification to the assignor within 6 months of the Medicare benefit being received.</p> <p>Will need to retain records of relevant documents for a specified period</p>

[#]With the provision that requirements of s20A(2) of the HI Act are already met.

[Proposed regulations and system changes required for the relevant legislative amendments](#)

Specific amendments to the HI Act which require the proposed changes to subordinate regulations and processes to support the assignment of Medicare benefits process are set out below. The Proposed Changes column was developed with recognition for current best practice whilst prioritising support for the integrity of Medicare payments in line with incoming legislation. Proposed regulation and system changes are intended to commence with the amendments of the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024* in January 2026.

Table 3. AOB Act Schedule 1 Amendments relating to proposed changes to subordinate regulations and systems.

Item No.	Extract from Act once enacted	Explanation of amendments	Proposed Change/s
7	<p>Part II Medicare benefits 20AAA Simplified billing assignments: additional matters</p> <p><i>Insurer has arrangement with professional etc.</i></p> <p>(1) For the purposes of paragraph 20A(2)(e), this subsection applies to the assignor’s right to the payment of a medicare benefit in respect of a professional service rendered by, or on behalf of, a person (the professional) while hospital treatment or hospital substitute treatment is provided if:</p> <p>(a) any of the following conditions is satisfied:</p> <p>(i) the insurer concerned has an arrangement with the professional for the provision of treatment to persons insured by the insurer;</p> <p>(ii) in the case of hospital treatment authorised by the operator of a hospital (see subsection (7))—the insurer has an arrangement with the operator of the hospital for the provision of treatment to persons insured by the insurer, and the operator of the hospital has an arrangement with the professional under which treatment is provided to persons insured by the insurer;</p>	<p>Incoming Legislation:</p> <p>A new section will be created which sets out three pathways an assignor will be taken to have assigned the Medicare benefit:</p> <ul style="list-style-type: none"> under s20AAA(1) - the insurer has an arrangement (e.g., agreement) with the medical practitioner concerning the fees and charges for the service. under s20AAA(3) - the assignor makes a request to assign the benefit, which can be modified, post-service, by the healthcare provider (e.g., medical practitioner, hospital, organization), where not already assigned under s20AAA(1); or under s20AAA(5) - the services relate to complications and unplanned services provided because they are necessary, urgent, during treatment in which a service with benefit assigned under s20AAA(1) or (2) is provided. <p>The three pathways will be taken to assign the Medicare benefit respectively to:</p> <ul style="list-style-type: none"> the billing agent making the claim for the benefit, otherwise the private health insurer; or the approved billing agent or private health insurer outlined in the request; or <p>the approved billing agent or private health insurer to which the service was assigned.</p>	<p>Regulations for s20AAA(3) ‘Request’ Pathway:</p> <p>For s20AAA(3)(d), the regulations will set out the manner, form, and minimum required content of the assignor’s request to the medical practitioner, hospital, or organisation to assign their Medicare benefit to the billing agent or private health insurer. The below lists what is proposed to be included in the HI Regulations 2018. Under s20AAA(5), the assignment request will also cover complications and unplanned treatment rendered with a service assigned through the ‘request’ pathway.</p> <p>Manner of request/modification:</p> <ul style="list-style-type: none"> to be conducted prior to the service or as soon as practicable in cases of urgent and necessary care and modifications can be facilitated by a medical practitioner, other health professional, or individual that is authorised by the hospital or organisation under s20AAA(7) circumstances that require the request pathway (e.g., if the medical practitioner or hospital elects to bill for the service outside an existing arrangement with the insurer) <p>Form of request/modification:</p> <ul style="list-style-type: none"> the assignment must be in writing (including electronic and digital formats) verbal requests of an assignment will not be allowed

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	<p>(iii) in the case of hospital substitute treatment authorised by an organization (see subsection (7))— the insurer has an arrangement with the organization for the provision of treatment to persons insured by the insurer, and the organization has an arrangement with the professional under which treatment is provided to persons insured by the insurer; and</p> <p>(b) the arrangement or arrangements (as the case may be) cover (wholly or partly) a liability of the insurer, the operator of the hospital or the organization to pay fees and charges in respect of the professional service; and</p> <p>(c) the right to payment of the medicare benefit has not been assigned under an agreement entered into under subsection 20A(1).</p> <p>(2) For the purposes of subsection 20A(2A), if subsection (1) of this section applies to the assignor’s right to the payment of the medicare benefit in respect of the professional service, it is taken to be assigned to whichever of the following is applicable:</p> <p>(a) if the claim for the medicare benefit is made by an approved billing agent— the approved billing agent;</p> <p>(b) (b) otherwise—the insurer.</p> <p>Note: The insurer or approved billing agent must notify the assignor within 6 months of being paid the medicare benefit: see subsection 127(3).</p> <p>Request made by assignor</p> <p>(3) For the purposes of paragraph 20A(2)(e), this subsection applies to the assignor’s right to the payment of a medicare benefit</p>		<p>Content of request/modification:</p> <ul style="list-style-type: none"> • Patient ID – Patient name as it appears on their Medicare card, Medicare card number and reference, and private health insurance membership details. • Assignment Facilitator – Who is the request being made to (either the operator of the hospital (where subparagraph 20AAA(3)(a)(i) applies), the organisation who authorised the hospital-substitute treatment (where subparagraph 20AAA(3)(a)(ii) applies), or the health care professional (where subparagraph 20AAA(3)(a)(iii) applies)). • Provider ID/s – Names and Medicare provider numbers of the medical practitioners or health care professionals that are covered by the ‘requested assignment’. • Date of hospital or hospital-substitute treatment commencement – Date of admission for a professional service that is provided while hospital-treatment is being provided or the date of professional service for a professional service rendered while hospital-substitute treatment is being provided. • Basic Service Description – A description of the treatment and services part of the request or, for modified requests, information on the modified or additional treatment and services rendered. • Assignment Date – Date the patient/assignor agrees to assign the Medicare benefit. • Service costs – Associated costs of the treatment and services, including amount charged, amount paid, and amount outstanding. Each of these amounts should also note which benefits will be part of the assignment and which costs will be the responsibility of the patient. • Assignee ID – Name and ID of approved billing agent or registered private health insurer

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	<p>in respect of a professional service rendered by, or on behalf of, a person (the professional) while hospital treatment or hospital substitute treatment is provided if:</p> <p>(a) unless paragraph (b) applies—the medicare benefit is covered by a request made by the assignor for the purposes of this paragraph, in accordance with requirements specified in the regulations, to the following person (the responsible provider):</p> <p>(i) in the case of hospital treatment authorised by the operator of a hospital (see subsection (7))—the operator of the hospital;</p> <p>(ii) in the case of hospital substitute treatment authorised by an organization (see subsection (7))—the organization;</p> <p>(iii) in the case of hospital substitute treatment to which subparagraph (ii) does not apply—the professional; and</p> <p>(b) if a request mentioned in paragraph (a) has been modified, in accordance with requirements specified in the regulations, after the professional service is rendered, by the responsible provider or a person authorised by the responsible provider—the medicare benefit is covered by the request as modified; and</p> <p>(c) the request, or the request as modified (as the case may be), provides that the assignor’s right to the payment of the medicare benefit in respect of the professional service is to be assigned</p>		<ul style="list-style-type: none"> Facility/Location ID – Provider identifying information (e.g., provider number) regarding the hospital or location where the service will be or was rendered <p>To streamline this change, it is proposed that the details to be provided to the assignor is included in existing documentation such as Estimate of Fees forms, assignment of benefits to billing agent forms, patient election forms, and pre-admission forms that are generally part of the broader informed financial consent (IFC) process.</p> <p>The Office of the Commonwealth Ombudsman, in its capacity as the Private Health Insurance Ombudsman (PHIO), and the Australian Medical Association (AMA) have published information and guidelines on good informed financial consent practices. Best practice principles refer to information regarding total costs of treatment, benefits payable, and patient out of pocket costs being provided to the assignor prior to admission or as soon as practicable after the service (for urgent and emergency situations).</p> <p>Standardised wording:</p> <p>Under s20AAA(3), legislation requires assignments to be made by the assignor through the medical practitioner, hospital, or organisation. The department is proposing for the following standardised wording to be included in IFC forms or pre-admission documentation. This is noting that existing documentation may already contain some of the Content of request/modification particulars listed above (e.g., Basic Service Description and Service Costs).</p> <p>For medical practitioners:</p> <p><i>“I assign my right to Medicare and private health insurance benefits to [Assignee ID] in respect of each professional service rendered as [hospital or hospital-substitute treatment] by [Provider ID/s] at [Facility/Location ID] from [Date of hospital or hospital-substitute treatment commencement].”</i></p>

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	<p>to the insurer concerned or an approved billing agent; and</p> <p>(d) any requirements specified in the regulations are met; and</p> <p>(e) the right to payment of the medicare benefit has not been assigned under an agreement entered into under subsection 20A(1), or because of the operation of subsection (1) or (5) of this section.</p> <p>Note 1: The operator of the hospital, the organization or the professional (as the case may be) must, if asked to, give the assignor a copy of the terms of a request made under paragraph (3)(a): see subsection 127(4).</p> <p>Note 2: The operator of the hospital, the organization or the professional (as the case may be) must give the assignor a notification as soon as practicable after a request is modified under paragraph (3)(b): see subsection 127(5).</p> <p>(4) For the purposes of subsection 20A(2A), if subsection (3) of this section applies to the assignor’s right to the payment of the medicare benefit in respect of the professional service, it is taken to be assigned to the insurer or approved billing agent mentioned in paragraph (3)(c) of this section.</p> <p>Note: The insurer or approved billing agent must notify the assignor within 6 months of being paid the medicare benefit: see subsection 127(3).</p> <p>Complications and related urgent unplanned services</p> <p>(5) For the purposes of paragraph 20A(2)(e), this subsection applies to the assignor’s right to the payment of a medicare benefit in respect of a professional service rendered by, or on behalf of, a person (the professional) while hospital treatment or</p>		<p>For hospitals and organisations: <i>“I assign my right to Medicare and private health insurance benefits to [Assignee ID] in respect of each professional service listed in [refer to Provider ID/s list and associated services] rendered as [hospital or hospital-substitute treatment] authorised by [Assignment Facilitator] at [Facility/Location ID] from [Date of hospital or hospital-substitute treatment commencement].”</i></p> <p>For the two scenarios below (or similar), the medical practitioner will be responsible for ensuring they facilitate the assignor’s request to assign their Medicare benefits to an insurer or billing agent or bill the assignor directly outside of simplified billing processes.</p> <p>The hospital operator or the organisation:</p> <ul style="list-style-type: none"> • does not have an arrangement with a medical practitioner regarding the fees and charges for a service. • does not have confirmation that a medical practitioner is billing through an insurer arrangement (e.g., the medical practitioner is charging the assignor an out of pocket beyond the limits of a medical gap cover arrangement or their arrangement with the hospital). <p>Online Eligibility Check: The department understands that, for the majority of hospital and hospital-substitute treatment, the medical practitioner facilitates informed financial consent discussions with the eligible person. Once the treatment is scheduled, the eligible person can then provide IFC to the hospital with regards to their hospital stay and accommodation costs. The proposed change to Online Eligibility Check (OEC) Web Services is intended to support the IFC and assignment of benefit process. This provides greater certainty to the practitioner or the hospital submitting the claim that they are meeting the requirements of s20A(2) in making the claim.</p>

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	<p>hospital substitute treatment is provided if:</p> <p>(a) another professional service (the related professional service) is rendered while the hospital treatment or hospital substitute treatment is provided; and</p> <p>(b) the right to payment of the medicare benefit in respect of the related professional service is taken to be assigned to the insurer concerned or an approved billing agent because of the operation of subsection (1) or (3) of this section; and</p> <p>(c) the professional service:</p> <p>(i) is rendered for a complication that arises during the related professional service; or</p> <p>(ii) is unplanned but is rendered during planned treatment of which the related professional service is part, and is, in the view of the professional, necessary and urgent; and</p> <p>(d) the right to payment of the medicare benefit has not been assigned under an agreement entered into under subsection 20A(1), or because of the operation of subsection (1) of this section.</p>		<p>The department encourages medical practitioners and hospitals to provide patients with information on the costs relating to their admission, particularly for instances where the eligible person will be expected to pay an 'out-of-pocket' cost. Services Australia's OEC Web Services is designed to support this process by enabling hospitals, day surgeries, and other health care locations the ability to check the eligibility of a patient in relation to their Medicare and/or PHI status and obtain an estimate of 'out-of-pocket' expenses relating to a hospital stay, MBS services, and prosthetic and miscellaneous services. However, some stakeholders note that the current OEC service can be improved in terms of which input and output/return data fields are mandatory or optional, the accuracy of the PHI return information, and how the presenting illness codes can better align with the legislated clinical categories (which sets out the hospital treatments that must be covered by an insurer).</p> <p>To ensure accurate and up to date information is readily available for the hospital or practitioner to conduct OEC and good IFC discussions with the assignor, the department and Services Australia are proposing the below options:</p> <ul style="list-style-type: none"> • revise the presenting illness codes and ensure consistency with the clinical categories; and • enable more detailed PHI coverage information to be available to the hospital or practitioner (e.g., for Silver Plus products, which clinical categories are covered in addition to the minimum Silver tier cover).
8	<p>Part II Medicare benefits 20B Claims for medicare benefit</p> <p>(1) A claim for a medicare benefit in respect of a professional service must be made to the Chief Executive Medicare:</p> <p>(a) in accordance with any requirements set out in the regulations; and</p>	<p>Current legislation: This section outlines the manner in which a claim for a Medicare benefit must be made.</p> <p>The HI Act states that a Medicare claim must be submitted in accordance with the approved form. However, there is no approved form for all simplified billing services.</p> <p>Incoming Legislation:</p>	<p>Assignment Declaration in Claim</p> <p>Under regulations relating to making the claim, the medical practitioner, hospital, or relevant person will be required to indicate that the assignment of benefit requirements have been satisfied. The department is proposing to include a valid assignment being made as part of the particulars set out in HI Regulations 2018. This will be a mandatory field in all simplified billing claim channels administered by Services Australia.</p>

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	<p>(b) in the manner and form (if any) approved, by notifiable instrument, by the Chief Executive Medicare; and</p> <p>(c) within the period of 2 years, or such further period as is allowed in accordance with subsection (3A), after the rendering of the service.</p> <p>(2) Without limiting this section, regulations prescribing requirements for the purposes of paragraph (1)(a) may specify any of the following:</p> <p>(a) requirements that must be met before a claim can be made;</p> <p>(b) requirements relating to the content of a claim;</p> <p>(c) requirements relating to the giving of notifications before or at the time a claim is made.</p>	<p>The AOB Act will amend the HI Act to allow for regulations to be made concerning the manner in which a Medicare claim must be submitted.</p> <p>The regulations may include:</p> <ul style="list-style-type: none"> requirements that must be met before a claim can be made; requirements relating to the content of a claim; requirements relating to the giving of notifications before or at the time a claim is made. 	<p>Currently, there is an existing Assignment of Benefit Indicator field (“benefitAssignmentAuthorisedInd” data field) in Service Australia’s Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE) that is required for Medicare Only and Billing Agent claims.</p> <p>The department is proposing for this field to be amended as a declaration that the requirements of the assignment of benefits have been satisfied and be mandatory for all simplified billing claims. This field is also proposed to be expanded to indicate the type of assignment that was made (either an implied assignment or requested assignment). For each MBS item claimed by a medical practitioner, they will be required to attest that they have satisfied the legislative requirements for an assignment set out in s20A(2)(a)(b)(c) and (e) and select the type of assignment that underpins the claim, either 1) an insurer arrangement (implied assignment) or 2) a requested assignment.</p> <p>For manual claims or claims that are not submitted via ECLIPSE, this will require similar amendments to the relevant Services Australia forms and channels.</p>
11	<p>Part II Medicare benefits</p> <p>127 Assignor of medicare benefit to be given notifications etc.</p> <p>...</p> <p><i>Simplified billing assignments</i></p> <p>(3) A person contravenes this subsection if:</p> <p>(a) the person is an insurer or approved billing agent; and</p> <p>(b) an eligible person (the assignor) is taken to have assigned a medicare benefit to the insurer or approved billing agent under subsection 20A(2); and</p> <p>(c) the medicare benefit is paid to the insurer or approved billing agent; and</p>	<p>Current Legislation:</p> <p>The HI Act states the medical practitioner may only enter into an arrangement for assignment of benefits with the eligible person, if the approved form is used and also if a copy of the assignment is provided to the eligible person as soon as practicable after the assignment. However, this requirement does not apply to all simplified billing assignments.</p> <p>Incoming Legislation:</p> <p>There are new penalty provisions if certain requirements are not met by insurers, billing agents, hospitals or medical practitioners concerning assignment of benefits for simplified billing.</p> <p>It will also allow for regulations to be made concerning requirements for the insurer or billing agent to provide the assignor with a notification of the assignment of benefits</p>	<p>In relation to notification to the assignor after receipt of the Medicare payment, the department understands that billing agents and private health insurers already provide a summary of benefits to patients.</p> <p>In relation to the provision of a copy of the ‘terms of the request’ if an assignor requests a copy, the inclination is to align with current informed financial consent best practice. Following on the proposed changes in Item 7, the medical practitioner facilitates a written patient request to assign their benefit in addition to or within the documentation indicating the services to be provided/rendered, costs of the services, MBS benefits, insurer benefits, and out of pocket costs.</p> <p>Stakeholder responses are requested to advise the department if they or their organisation provides a copy of</p>

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	<p>(d) the insurer or approved billing agent does not give the assignor a notification:</p> <p>(i) in accordance with any requirements specified in the regulations; and</p> <p>(ii) within 6 months of the payment.</p> <p>Civil penalty: 5 penalty units.</p> <p>(4) A person contravenes this subsection if:</p> <p>(a) the person is a responsible provider mentioned in paragraph 20AAA(3)(a); and</p> <p>(b) an eligible person (the assignor) makes a request for the purposes of paragraph 20AAA(3)(a) to the responsible provider; and</p> <p>(c) the assignor asks the responsible provider for a copy of the terms of the request; and</p> <p>(d) the responsible provider does not ensure that the assignor is given a copy of the terms of the request as soon as practicable after the assignor asks for it.</p> <p>Civil penalty: 5 penalty units.</p> <p>(5) A person contravenes this subsection if:</p> <p>(a) the person is a responsible provider mentioned in paragraph 20AAA(3)(b); and</p> <p>(b) an eligible person (the assignor) makes a request for the purposes of paragraph 20AAA(3)(a) to the responsible provider; and</p> <p>(c) the responsible provider, or a person authorised by the responsible provider, modifies the request as mentioned in paragraph 20AAA(3)(b); and</p>	<p>for simplified billing, and for this notification to occur within 6 months of the payment of the MBS benefit. There will be a civil penalty of 5 penalty units if the requirements are not met.</p> <p>As per the changes to s20AAA(3):</p> <p>It will require the medical practitioner, hospital, or billing agent to provide the assignor with a copy of the ‘terms of the request’ for the assignment of benefits as soon as practicable after the assignor requests it. There will be a civil penalty of 5 penalty units if the terms of the request are not provided as soon as practicable.</p> <p>It will also require the medical practitioner, hospital, or billing agent to provide the assignor with a notification where the request is modified, in accordance with the regulations, and for this notification to occur as soon as practicable after the modification. There will be a civil penalty of 5 penalty units if the modified request is not provided as soon as practicable.</p> <p>The regulations may include:</p> <ul style="list-style-type: none"> • requirements relating to the content of the notification to be given; • requirements relating to the manner and form in which the notification is to be given; and circumstances in which the notification must be given. 	<p>informed financial consent documentation and it is: provided to patients in all instances, only if requested, or not at all.</p> <p>Period for Notification</p> <p>Under s127(3)(d)(ii), the period for an insurer or billing agent to notify an assignor is “within 6 months of payment”. Within the context of s127(3), this is defined as insurers or billing agents sending written notification to the assignor within 6 months of receiving the benefit from Medicare for a service taken to be assigned under s20A(2).</p> <p>Under s127(4)(d) and (5)(d)(ii), the term ‘as soon as practicable’ is intended as a matter of weeks but not months after the assignor has made the request. However, the department accepts that this time period can extend to after services are rendered or after the assignor has been discharged under some circumstances.</p>

Item No.	Extract from Act once enacted	Explanation of amendments	Proposed Change/s
	<p>(d) the responsible provider does not ensure that the assignor is given a notification:</p> <p>(i) in accordance with any requirements specified in the regulations; and</p> <p>(ii) as soon as practicable after modifying the request.</p> <p>Civil penalty: 5 penalty units.</p>		
11	<p>Part II Medicare benefits</p> <p>127 Assignor of medicare benefit to be given notifications etc.</p> <p>...</p> <p><i>Notification obligations in regulations</i></p> <p>(6) A person contravenes this subsection if:</p> <p>(a) under regulations made for the purposes of paragraph 20A(6)(c), 20AAA(8)(c) or 20B(2)(c), the person is required to:</p> <p>(i) give a notification to an eligible person; or</p> <p>(ii) ensure that a notification is given to an eligible person; and</p> <p>(b) the person contravenes those regulations; and</p> <p>(c) those regulations specify that this paragraph applies.</p> <p>Civil penalty: 5 penalty units.</p> <p><i>Regulations</i></p> <p>(7) Without limiting this section, regulations prescribing requirements for the purposes of this section in relation to the giving of a notification may specify:</p> <p>(a) requirements relating to the content of the notification to be given; and</p> <p>(b) requirements relating to the manner and form in which the notification is to be given; and</p>	<p>Incoming Legislation:</p> <p>There are new penalty provisions if certain requirements are not met by insurers, billing agents, hospitals or medical practitioners concerning assignment of benefits for simplified billing.</p> <p>It will also allow for regulations to be made concerning requirements for the insurer, billing agent, medical practitioner, or hospital to provide notification to the assignor, including:</p> <ul style="list-style-type: none"> • the assignment of the right to payment of a medicare benefit; and/or • any claim for a medicare benefit assigned. 	<p>In relation to the notification requirements, the inclination is to align with current informed financial consent best practice and existing notification processes by billing agents and private health insurers.</p>

Item No.	Extract from Act once enacted	Explanation of amendments	Proposed Change/s
	(c) in the case of regulations made for the purposes of paragraph (2)(c)— circumstances in which the notification must be given.		
11	<p>Part II Medicare benefits 127A Record keeping in relation to assignments <i>Persons to keep relevant records</i></p> <p>(1) A professional mentioned in subsection 20A(1), an insurer or an approved billing agent (a relevant person) must keep all records of a kind specified by the regulations that are relevant to the following:</p> <p>(a) the assignment of the right to payment of a medicare benefit to the relevant person under section 20A;</p> <p>(b) any claim for a medicare benefit assigned to the relevant person made under section 20B;</p> <p>(c) any matter specified in the regulations.</p> <p>(2) Subsection (3) applies if:</p> <p>(a) the right to the payment of a medicare benefit in respect of a professional service is taken to have been assigned under subsection 20A(2); and</p> <p>(b) the professional service was rendered by, or on behalf of, a person (the professional) while hospital treatment or hospital substitute treatment was provided.</p> <p>(3) The following person (also a relevant person):</p> <p>(a) in the case of hospital treatment authorised by the operator of a hospital (see subsection 20AAA(7))— the operator of the hospital;</p> <p>(b) in the case of hospital substitute treatment authorised by an</p>	<p>Incoming Legislation:</p> <p>There are new penalty provisions if certain requirements are not met by insurers, billing agents, hospitals or medical practitioners concerning assignment of benefits for simplified billing.</p> <p>It will require the records to be kept in an electronic form or another form approved by the Secretary.</p> <p>It will also require the records to be retained until the latest of the following:</p> <ul style="list-style-type: none"> • 2 years after the agreement or arrangement for the assignment of benefits ceases to be in force • 2 years after the day on which the records were created • a date specified in the regulations for records of a specified kind • There will be a civil penalty of 5 penalty units if the records are not retained for the relevant period of time. 	<p>Record-keeping Requirements</p> <p>In relation to the record-keeping requirements, the department intends to clarify in the regulations the parties that will be required to keep records and which records should be kept. The below lists what is proposed to be included in the HI Regulations 2018. Stakeholders should consider records that are already being kept or are already required to be kept and provide feedback to the department.</p> <p>Records to be kept by private health insurers:</p> <ul style="list-style-type: none"> • record of the CHIP that covers the patient for the service at the date of service • agreements or contracts with the medical practitioner, hospital, or relevant organisation if a service is paid through the agreement • record of the notification of Medicare benefits received that is provided to the assignor <p>Records to be kept by billing agents:</p> <ul style="list-style-type: none"> • record of the notification of Medicare benefits received that is provided to the assignor <p>Records to be kept by medical practitioner:</p> <ul style="list-style-type: none"> • agreements with the insurer regarding the fees and charges for the service that is active for the date of service • record of the request for assignment (as per s20AAA(3)) and any modifications to the request • as per s20AAA(5), evidence of a service being related to the originally assigned service and rendered following a complication or evidence of the service being unplanned but is necessary, urgent, or as part of planned treatment • as per s20AAA(1)(A)(ii) and (iii), and s20AAA(7), agreements with the hospital or organisation

Item No.	Extract from Act once enacted	Explanation of amendments	Proposed Change/s
	<p>organization (see subsection 20AAA(7))—the organization;</p> <p>(c) in the case of hospital substitute treatment to which paragraph (b) does not apply—the professional;</p> <p>must keep all records of a kind specified by the regulations that are relevant to the following:</p> <p>(d) the assignment of the right to payment of the medicare benefit;</p> <p>(e) any matter specified in the regulations.</p> <p><i>Record keeping requirements</i></p> <p>(4) The records must be kept in:</p> <p>(a) an electronic form; or</p> <p>(b) another form approved by the Secretary.</p> <p>(5) The records must be retained until the latest of the following:</p> <p>(a) if the record is an agreement entered into under subsection 20A(1) or an arrangement mentioned in paragraph 20AAA(1)(a)—2 years after the agreement or arrangement ceases to be in force;</p> <p>(b) 2 years after the day on which the records were created;</p> <p>(c) if the regulations specify a day for records of a specified kind, and the records are of that kind—that day.</p> <p><i>Civil penalty provision</i></p> <p>(6) A relevant person contravenes this subsection if the relevant person fails to:</p> <p>(a) keep the records required by subsection (1) or (3); or</p> <p>(b) keep the records in the form required by or under subsection (4); or</p> <p>(c) retain the records for the period required by or under subsection (5).</p> <p>Civil penalty: 5 penalty units.</p>		<p>Records to be kept by the hospital, hospital operator or organisation:</p> <ul style="list-style-type: none"> • contracts with the insurer regarding the fees and charges for the service that is active for the date of service • record of the request for assignment (as per s20AAA(3)) and any modifications to the request as per s20AAA(7), agreements or contracts with the medical practitioners or an organisation as per s20AAA(5) and (7), evidence of the service being related to the originally assigned service and rendered following a complication or evidence of the service being unplanned but is necessary, urgent, or as part of planned treatment

Item No.	Extract from Act once enacted	Explanation of amendments	Proposed Change/s
	<p><i>Regulations</i></p> <p>(7) Without limiting this section, regulations prescribing kinds of records, or matters to which records are relevant, may specify different kinds or matters for different classes of person.</p>		

Guidance Questions

The department seeks feedback on the proposals outlined and invites stakeholders to provide input by responding to the following questions as relevant and highlighting the regulatory impact of each proposed change:

Online Eligibility Check Web Services

- Are the current information inputs and outputs in the OEC web service sufficient for a hospital or medical practitioner to determine whether the patient has a CHIP that provides coverage for the service, enable good IFC discussions to be conducted, and to facilitate a valid assignment of the Medicare benefits?
- Should the list of presenting illness codes include all legislated clinical categories?
- Which request and insurer response fields in OEC should be amended, introduced, or removed?

Assignment Declaration in Claim

- What is the impact of the mandatory assignment of benefit declaration on the organisation and billing or claims processing software?

S20AAA(1) 'Implied' Assignment Pathway

- Are practitioners providing services in public hospitals to private patients eligible for medical gap cover arrangements, purchaser provider agreements, or any other insurer arrangements?

Regulations for s20AAA(3) 'Requested' Assignment Pathway

- Medical practitioners (surgeons, assistant surgeons, anaesthetists, pathologists, and radiologists, etc.), hospitals, and organisations are invited to provide examples of how and when IFC discussions are facilitated. If IFC is not provided to the patient or assignor, stakeholders should also advise under which circumstances these apply.
- Feedback is sought on the assignment particulars and the standardised wording proposed to facilitate the assignor's request to assign their Medicare benefit to the insurer or billing agent via the medical practitioner, hospital, or organisation.
- How do practitioners and hospitals manage post-service IFC processes in instances where there is a complication, unplanned treatment, or modification to the service originally planned?
- For the description of treatment and services part of the request, feedback is sought on the level of specificity that accurately conveys what the service or treatments are and reasonable accommodations (i.e., descriptions of a technical nature may require modifications to the original assignment request or multiple assignment requests).

Record-keeping

- Stakeholder feedback is requested on the list of documents that the relevant stakeholder should keep. These documents provide the basis for an 'implied' or 'automatic' assignment under s20AAA(1) or a 'requested' assignment under s20AAA(3) and is proposed to be included in the HI Regulations 2018.
- Stakeholders should consider records that are already being kept or are required to be kept in providing feedback on the proposed list of records set out in pages 14 and 15.

Claims Payment

- For insurers, are there timeframes for claims processing and claims payment to the provider after they have submitted the claim to the insurer or after the insurer has received the ECLIPSE claim?
- In which circumstances are claims paid later than 6 months from the day the insurer receives it?
- Do insurers provide notification if there is a delay in the claims processing or benefit payment?

Notification

- Stakeholders are invited to provide feedback on:
 - billing agent and insurer timeframes for notification to patients,
 - confirmation if their organisation conducts this notification process, and
 - the method this notification is provided to the assignor (e.g., physical letter or electronic means, etc.).
- For insurers and billing agents, is the statement of benefits generally sent to the patient, the assignor or another individual related to the patient?

IFC and Financial Disclosures

- Do stakeholders provide patients with a copy of informed financial consent documentation at each instance of IFC or only if requested?
- Stakeholders are invited to provide the department with copies or templates relating to the assignment of a benefit, benefit statements, or similar documentation that they provide patients.

The Department welcomes all feedback, including additional measures or proposals to address the topics outlined in this paper.

How to respond

Please submit your response via email to AssignmentofBenefit@health.gov.au by **28 March 2025**.

To support stakeholder engagement, the department intends to publish responses. Respondents are asked to clearly identify specific elements of the response which are considered confidential and not for publication, as well as the reasons the specific elements are considered confidential. Confidential feedback may still be subject to access under freedom of information laws. The freedom of information process includes consultation with a respondent prior to a decision about the release of information.

Documents provided to the department should consider privacy provisions and should not contain personal or identifying information included without consent.