Australian Government
Department of Health, Disability and Ageing

FACT SHEET
Modernising gap-only billing – replacing Medicare cheques with electronic benefit payments

Cessation of Medicare cheques

- The government intends to cease issuing cheques by 1 July 2028, including Medicare benefits cheques and cheques issued under the Child Dental Benefit Schedule (CDBS).
- Medicare and CDBS benefits cheques are currently issued to pay part of the fee – the Medicare benefit component - for health services provided under gap-only billing arrangements.

Current gap-only billing arrangements - PDVC

- Currently, doctors and some other health service providers can charge patients the gap amount only of the full fee. The full fee is made up of 2 components - the gap component and the Medicare benefit component.
- Gap-only billing is currently processed via Pay Doctor Via Claimant (PDVC) arrangements. The patient pays the gap amount to the doctor. The Medicare benefit is then sent to the doctor via the patient, in the form of a cheque, to deliver to the doctor.
- If the doctor does not receive the cheque within 90 days the Medicare benefit is usually sent to the doctor via electronic funds transfer (EFT).

Modernised gap-only billing arrangements

- With the removal of cheques by 1 July 2028, modernised gap-only billing arrangements are being considered to assist with affordability for high cost Medicare services that are not bulk billed. Modernised arrangements would commence by 1 July 2028.
- Under modernised gap-only billing, patients would pay the gap component only of the provider's fee (no change).
- After the patient has paid all of the gap amount, the provider would submit an electronic Medicare claim for the service to Services Australia (Medicare) and receive the Medicare benefit directly via EFT after 90 days.

Eligibility for gap-only billing arrangements

- All patients and all providers would be eligible to use gap-only billing for services where the Medicare Benefits Schedule (MBS) fee exceeds $697 (at 1 November 2025, indexed annually). Gap-only billing arrangements would not be available for services where the MBS fee is less than $697.
- Gap-only billing arrangements would not be available for services rendered under the CDBS.

Why would gap-only billing be available for high cost services only?

- Gap-only billing arrangements are being modernised to assist with affordability of high cost services where bulk billing is not offered.
- To mitigate the risk of fee inflation and preserve bulk billing rates, gap-only billing would not be available for lower cost services.
- Many bulk-billed services now attract incentives for the provider to bulk bill, including GP Non-Referred attendances.

Why would Medicare benefits be paid after 90 days?

- A 90 day payment delay would preserve the attractiveness of bulk billing (immediate payment) relative to gap-only billing.
- A 90 day payment delay is in line with existing arrangements where the payment is delayed by up to 90 days if a cheque is not forwarded by the patient to the provider.

How is the threshold for high cost services defined?

- A high cost service is defined as a service where the MBS fee is greater than $697 (as at 1 November 2025 and indexed annually). This is the fee at which the Greatest Permissible Gap (GPG) is applied. The GPG is a regulated amount which helps to reduce out-of-pocket costs for Medicare services.

What does this mean for providers?

- The administrative burden and payment uncertainty associated with cheque processing would be removed.
- Providers choose how to bill patients. Providers are not required to use current PDVC billing and would not be required to use gap-only billing. Providers can instead choose other billing arrangements including bulk billing or patient billing.
- If they choose to use gap-only billing, providers would be required to submit Medicare claims for services electronically, after the patient has paid all of the gap amount.

What does this mean for patients?

- If a service is not bulk billed, patients can ask their provider whether they can pay the gap amount only to help with affordability.
- Patients would be required to pay all of the gap amount before the provider can submit a gap-only Medicare claim.
- Patients would not need to handle cheques.

What would the transitional arrangements be?

- Claims submitted until June 2028 would be paid using current PDVC arrangements.
- Claims submitted from 1 July 2028 (including any claims submitted in late June 2028 but not assessed) would be paid under modernised gap-only billing arrangements.

How would the impact of the changes be monitored?

- The department would monitor the impact of gap-only billing arrangements on patient access, fee inflation and bulk billing rates and provide advice to Government.