DOVE CARE GROUP
Health care Products

Delivering Dignity

BILLER AUTHORITY DEED

This Deed must be completed and submitted to the Dove Care Group by the Participants or Organisation responsible for paying the invoices. This Deed will enable the Client (or their representative) to place orders.

For NDIS customers, please email: **admin@dovecaregroup.com.au**

Please ensure all details are completed and accurate before submitting for processing.

Section 1

(Please fill in this section if Dove Care Group to claim directly from the NDIA)

Recipient First Name (Client):	
Recipient Last Name (Client):	
Date of Birth: (mandatory for NDIS)	
Recipient Email Address:	
Recipient Contact Number:	
Recipient Address:	
Funding Type: (e.g. NDIS, HCP)	
Recipient Reference #: (e.g. NDIS#, Claim#)	
Shipping Address: (if not same as Recipient Address)	
Funding Start Date:	
Funding End Date:	
Expected Spend During Funding Period:	
Recipient Account Code: (if known)	
Other Notes:	

Authority to Leave Shipment: (tick)	No Yes

Section 2

(Please fill in this section if the invoice is paid by a Client Representative or an Organization)

Recipient First Name (Client):	
Recipient Last Name (Client):	
Date of Birth: (mandatory for NDIS)	
Recipient Email Address:	
Recipient Contact Number:	
Recipient Address:	
Funding Type: (e.g. NDIS, HCP)	
Recipient Reference #: (e.g. NDIS#, Claim#)	
Shipping Address: (if not same as Recipient Address)	
Funding Start Date:	
Funding End Date:	
Expected monthly spend (with Dove Care Group) during Funding Period:	
Recipient Account Code: (if known)	
Other Notes:	
Authority to Leave Shipment: (tick)	No Yes
Recipient Account Code: (if known)	
Other Notes:	

NDIS Number: (nine-digit number)	
Biller Name: (Funding Manager)	
ABN:	
Biller Postal Address:	
Biller Email Address: (for invoices & statements)	
Biller Contact Name:	
Biller Contact Phone #:	

The Provider:

- acknowledges that they will be liable for knowingly placing an order that exceeds the Recipient's funding balance or was aware/could foresee that the client's funding would be insufficient to meet the total cost of the order or the items ordered are not covered under the client's plan
- is solely responsible for advising Platinum Health Supply in writing if the client's fund is materially reduced or ceases.
- has obtained the authority of their client to use and share the information to facilitate the fulfillment of orders.

Signed as an Agreement for the Provider

Provider: _____

Name (print): _____

Business Title: _____

Date: _____/ _____/ _____(DD/MM/YYYY)