

Assignment of Benefits

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Important update

The Department of Health, Disability and Ageing has amended the Medicare Assignment of Benefits legislative requirements to support a 12-month transition period for bulk-billing Medicare and DVA. This includes enabling verbal assignment of benefit for all bulk-billed patients, in all settings. <https://www.health.gov.au/our-work/improving-the-assignment-of-benefit-process>

Assignment of Benefit (AoB) allows a patient to give consent, or “assign”, their Medicare benefit to a doctor or health fund. An AoB approval can be provided by the patient **before** or **after** an appointment using paper or digital forms. This guide explains the information required and Zedmed's post-approval functionality.

To learn more, see the [AOB post-assignment approval guide](#) and Zedmed [AoB Webinar & FAQ](#)

MBS Services

Pre-Assignment of Benefit

A practice can use AoB pre-assignment approval for high-certainty appointments, provided that the required information is recorded.

Information required in a pre-assignment:

1. Indication that it is 'pre-assignment'
2. Patient Name
3. Date of assignment
4. Record if the assignor is the patient (Yes/No)
5. Details of the professional providing the service
6. Date of service
7. [Basic Service Description](#)

Basic Service Descriptions

A patient's AoB pre-assignment approval must include a Basic Service Description(s). The Department of Health provides a list of 'Basic Service Descriptions' to which all MBS items are mapped. These are determined by service characteristics, provider type, time tiering and compliance considerations. The descriptions are available through [MBS Online](#).

Service changes

The pre-assignment approval becomes **invalid** if any of the seven listed items change during the appointment. In this case, a post-assignment approval is required.

Exception: If **only** the service item changes, the AoB remains valid *as long as* the Basic Service Description is still

correct.

Post-Assignment of Benefits

A practice should use post-assignment approvals for low-certainty appointments, and the approval must include information noted below.

Information required in a post-assignment:

1. Indication that it is 'post-assignment'
2. Patient Name
3. Date of assignment
4. Record if the assignor is the patient (Yes/No)
5. Details of the professional providing the service
6. Date of service
7. MBS item(s)

Pathology and Imaging

Pathology and Imaging providers can use AoB pre-assignment and post-assignment approvals, provided the form captures the required information. If current laboratory forms do not include some required information, a sticker can be added to the missing field/s until compliant forms are available.

Assignment Type	Pathology (excluding Group 9)	Diagnostic Imaging
Pre-assignment	<ul style="list-style-type: none">• Patient name• Date of assignment• Assignment type (pre-assignment)• Is the assignor the patient – yes/no• Date of specimen collection• Statement of assignor's agreement*• Description of the service	<ul style="list-style-type: none">• Patient name• Date of assignment• Assignment type (pre-assignment)• Is the assignor the patient – yes/no• Date of imaging procedure• Statement of assignor's agreement (R type services)[#]• Description of the service
Post-assignment	<ul style="list-style-type: none">• Patient name• Date of assignment• Assignment type (post-assignment)• Is the assignor the patient – yes/no• Date of specimen collection• Details of the professional (per Section 54 of the HIR)• MBS item/s	<ul style="list-style-type: none">• Patient name• Date of assignment• Assignment type (post-assignment)• Is the assignor the patient – yes/no• Date of imaging procedure• Details of the professional• MBS item/s

Zedmed's AoB support

Bulk Billing post-assignment

Zedmed's billing workflows will support **AoB post-assignment requests** with the release of Zedmed v39.5. This update will be released before 1 July 2026 and complies with the Assignment of Benefit requirements. The AoB post-assignment request is sent to the patient via SMS. Once approved, the approval will be displayed on the New Invoice and Claims screens and recorded in Account Enquiry for audits.

The practice can follow two possible workflows as documented in the **AoB post-assignment approval guide**

- Send the post-assignment approval SMS to the patient when billing and get approval at reception.
- Suppress all invoices, send the approval SMS and at the end of the day, filter claims before transmitting to Medicare.

Bulk Billing pre-assignment

Zedmed will be releasing an electronic AoB pre-assignment approval form in Q3 (July-Sept) 2026. Prior to this, practices may develop their own AoB pre-assignment approval form.

Eclipse (Health Fund) approval

To comply with the changes, Zedmed's **ECLIPSE billing** will require selecting either **Implied Assignment** or **Requested Assignment** when submitting a claim. This update will be available in Zedmed v39.4.

Implied Assignment

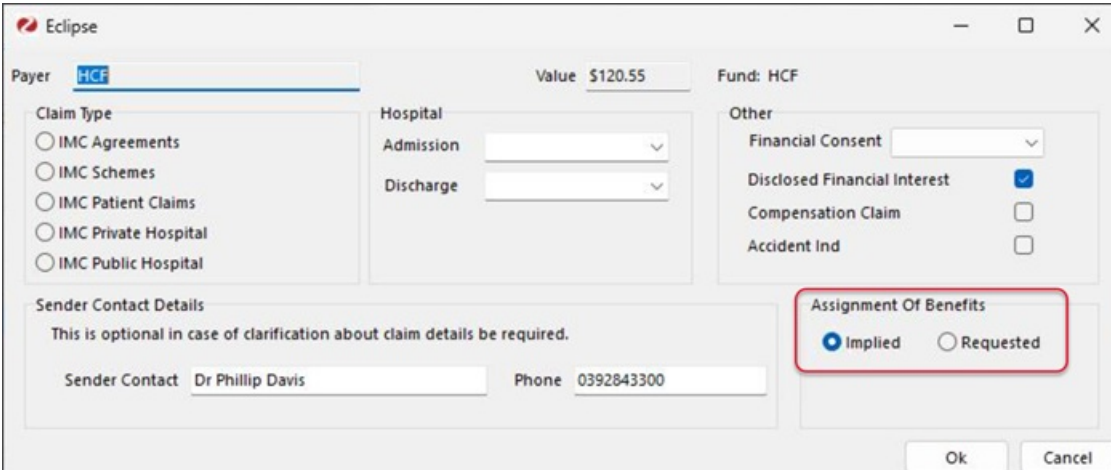
An insurer arrangement applies to the service (e.g., gap cover agreements or MPPAs, etc.). This is an automatic assignment of the Medicare benefit to a private health insurer or approved billing agent.

No explicit patient signature is required but records relevant to the assignment must be retained. The ECLIPSE claim form can be used for this.

Requested Assignment

A health fund arrangement does not apply to the service (e.g., contracts relating to hospital accommodation, theatre fees, etc., but not medical services). A manual assignment request by the patient facilitated by the medical provider, hospital or organisation before or after the service. The practitioner needs to facilitate the assignor's request to assign the Medicare benefit to the fund.

The patient's approval is usually captured implicitly as part of the Informed Financial Consent (IFC) process when they agree to the hospital/gap scheme. The practice should check their own process meets the AoB requirements, as approval is not recorded in Zedmed.



The screenshot shows the Eclipse software interface for submitting a claim. The window title is "Eclipse". The "Payer" field is set to "HCF", the "Value" is "\$120.55", and the "Fund" is "HCF".

The "Claim Type" section has five radio button options: "IMC Agreements", "IMC Schemes", "IMC Patient Claims", "IMC Private Hospital", and "IMC Public Hospital".

The "Hospital" section has two dropdown menus: "Admission" and "Discharge".

The "Other" section has three checkboxes: "Financial Consent" (checked), "Disclosed Financial Interest" (checked), "Compensation Claim" (unchecked), and "Accident Ind" (unchecked).

The "Sender Contact Details" section has a note: "This is optional in case of clarification about claim details be required." Below this, there are fields for "Sender Contact" (Dr Phillip Davis) and "Phone" (0392843300).

The "Assignment Of Benefits" section is highlighted with a red box and contains two radio button options: "Implied" (selected) and "Requested".

At the bottom right, there are "Ok" and "Cancel" buttons.

To learn more, see the [Department of Health, Disability and Aging guidance](#)