Assignment of Benefits FaQ

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Zedmed can only advise on questions related to our integration; however, we have included some answers from the Department of Health FAQ that clarify when Zedmed's electronic post-assignment approval should be used.

Additional resources:

- Zedmed AoB post-assignment requests guide
- Zedmed AoB guidance and changes article
- The Department of Health article and FaQ

What if a claim is rejected?

If a claim is rejected by Medicare, a new AoB post-assignment approval may be required. For example, if it was rejected for the incorrect practitioner, the wrong or duplicate service item on a post-assignment approval, or a service item in the wrong Basic Service Description for a pre-approval.

If an incentive item is added during the consultation, will that require approval?

If the incentive item falls under a Basic Service Description that was **not** used for the pre-assignment approval, a post-assignment approval will be required. Zedmed will be updating how this is managed to avoid this scenario.

What is required for a patient to approve (sign) their AoB?

From **1 July 2026**, verbal AoB agreements are no longer valid. Patients (or their representatives) must provide a physical or electronic signature that is identifiable, auditable and compliant with the *Electronic Transactions Act 1999*.

Zedmed SMS Approvals Are Compliant: The Department of Health has reviewed our process and confirmed that sending an SMS to the patient and recording an **'Accept'** response successfully meets all digital signature requirements.

Can I submit a claim in Zedmed without an AoB approval?

Zedmed does not prevent claims from being submitted. The claims screen lets you sort suppressed claims by approval status: Approved /Not approved.

How long should AoB approvals be kept for?

The patient's approval must be retained for two years.

What if a patient cannot assign their benefit to themselves?

The AoB can be sent via SMS to the person providing the approval, who may not be the patient. The approval will indicate that the signer is not the patient but someone acting on their behalf, for example, a NOK. See the Responsible person guidance for more information.

Do adults accompanying children need to be a legal guardian

No. An assignment only needs to be made by the person, or 'assignor,' who would otherwise meet the cost of the medical service if it were not being bulk billed. While this often is a parent, guardian, or carer, it is not limited to these relationships.

What if a patient is unable to give consent (e.g Age Care)?

Zedmed provides a solution for requesting and saving a patient's AoB consent. If the patient is unable to give consent, the practice should follow its own internal process using the guidance provided by Services Australia.

What if a patient will not approve their AoB?

If the patient does not agree to assign their Medicare benefit, they should be privately billed and provided with an invoice to enable them to claim their Medicare benefit from Services Australia.

For unpaid and partially paid accounts, the patient may request that a cheque for the Medicare benefit is sent by Services Australia to the patient to send to the provider. Further information can be found on Services Australia's website 90 day pay doctor cheque scheme - Health professionals - Services Australia

Are there scenarios where verbal consent can be given after 1 July 2026?

From 1 July 2026, an AoB agreement will not be available verbally, rather, an electronic or physical signature will be required. The record must be auditable and a signature must be compliant with the Electronic Transactions Act 1999.

What if the patient can not receive an SMS?

You can print a physical AoB form when invoicing by selecting **Print** when prompted after selecting **Bulk Bill**. This PDF can be printed and emailed to the patient, who can sign it, scan it and send it back. Zedmed is also developing an email option.

What if a patient does not receive the SMS?

Zedmed's Post-Assignment approval SMS can be resent. You can confirm if it was sent by checking the Message tab in the patient's record.

What if the patient pays using Tyro?

If you are using Tyro Easyclaim, you can print a practice receipt containing all the AoB approval information required on the terminal. This is important for customers who are using Tyro as a stand-alone payment solution (not integrated with Zedmed).

The practice receipt:

- Must be selected when prompted on the terminal, after the patient receipt has been printed.
- Is not stored electronically, so it must be printed.
- Store the receipt in a low-light environment or scan/photograph as it will need to be retained for 2 years.

In July, Tyro Health will release an updated AoB solution for the Pro Key terminal that saves post-assignment approvals electronically within Tyro Health Online. Tyro will be sending communications to its customers when this feature becomes available.

Do general practitioners (GPs) need new pathology request forms, and what will happen to the existing ones?

Any pathology request forms issued to patients prior to 1 July 2026 will remain valid for AoB purposes for up to 12

months. However, any request issued to patients after that date must comply with the new AoB requirements.

If request forms are used which do not reflect the new assignment 'data set,' a patient's assignment could be obtained when they are at a collection centre to have a specimen taken. Options would be to amend the old form to include any missing information or use a new AoB agreement in hard or electronic copy.

Similarly, if a specimen is collected in a practice by a GP, the required information could be added to an old request, or the receiving pathologist could seek a patient's post-service assignment agreement.

What is the process for rejected or resubmitted claims during the transition?

Rejections and adjustments will be managed by Services Australia as per existing processes. For all services other than pathology, if the assignment for a claim occurred before 1 July 2026 and the resubmission or adjustment occurs after 1 July 2026, the health professional will need to ensure the patient/claimant has agreed to assign their benefit using a document that complies with the new requirements outlined in the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.

For pathology services, as per regulations the agency will either accept the existing offer to assign (for 12 months) or they will be required to obtain the assignment of benefit again using a document that complies the new requirements outlined in the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025. Please note new versions of the existing forms for these processes will be made available to health professionals to coincide with the 1 July 2026 changes.

Is it possible to have one assignment of benefit for multiple services?

Scenario 1 – Multiple services with the same practitioner on the same day In this scenario, multiple services may be included under a single AoB agreement if the provided services correspond to those listed and are rendered by the same practitioner. Otherwise, an additional AoB agreement will be required.

Scenario 2 – Multiple services with multiple practitioners from different practices on the same day In this scenario, separate AoB agreements would be required. Multiple services by a single practitioner may be listed on the same agreement.

Scenario 3 – Multiple services with multiple practitioners at the same practice on the same day In this scenario, separate AoB agreements would be required. The provided services should correspond to those listed on the AoB agreement by the same practitioner.

How will this work in aged care and nursing home settings?

An AoB for bulk billed services is required in aged care settings. Where a patient lacks mental or physical capacity to make their own financial or health decisions, an assignor can do so on their behalf. Under the Health Insurance Act 1973, an assignor is a person who would otherwise meet the cost of medical expenses. In practical terms this is usually a carer, partner, parent, or a person with Power of Attorney.