

BILLER AUTHORITY DEED

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

For NDIS, home care and other funded customers, please email completed form to ndis@joyamedicalsupplies.com.au

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

Only complete section 1 if you want Joya medical supplies, to claim directly from NDIA Participant’s representative care provider and organisation responsible for paying invoice please complete both section.

Please complete both pages of the Biller Authority Form before submitting.

Section 1

Recipient Name (Client):

Recipient Address:

Funding Type: (e.g. NDIS, HCP)

Recipient Reference:(eg. number)

Date of Birth: (mandatory for NDIS)

Recipient Contact Number:

Recipient Email Address:

Funding Start Date:

Funding End Date:

Expected monthly Spend During Funding Period (With Joya):

Other Notes:

Authority to leave

YES

NO

If you select No, signature on delivery will be require, If no one home the parcel will be taken to nearest collection centre.

Section 2:

If invoice to be paid by client representative or organisation responsible to pay, please complete below section as well

Billor Name: (Funding Manager):

ABN:

Billor Postal Address:

Billor Email Address:
(for invoices & statements)

Billor Contact Name:

Billor Contact Phone #:

The Provider:

1. 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
2. is solely responsible for advising Joya medical supplies in writing if the client's fund is materially reduced or ceases.
3. has obtained the authority of their client to use and share the information to facilitate the fulfilment of orders.

Our Privacy Policy can be found at <https://joyamedicalsupplies.com.au/privacy-policy/>

Signed as an Agreement for the Provider

Provider: _____

Name (print): _____

Business Title: _____

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