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| --- | --- | --- |
| **Date** | | Click here to enter text. |
| **Individual provider** | **Full name** | Click here to enter text. |
| **Registration number** | Click here to enter text. |
| **Scope of practice** | Click here to enter text. |
| **Vocational scope** | Click here to enter text. |
|  |  |
| **Practice** | **Name of practice/facility** | Click here to enter text. |
| **Named contact** | Click here to enter text. |
| **Email address**  *For remittance advice & all other communications* | Click here to enter text. |
| **Practice/facility phone number** | Click here to enter text. |
| **Physical address of practice/facility** | Click here to enter text. |
|  |  |
| **Billing** | **Company name**  *If applicable* | Click here to enter text. |
| **Practice/facility billing** | One billing account  Per individual specialist |
| **Bank account details** | Name of account: Click here to enter text.  Name of bank: Click here to enter text.  Bank account number: Click here to enter text.  *(Bank-Branch-Account-Suffix)* |
| **Bank account verification** | I am supplying:  Bank deposit slip  Bank statement  *Please supply one of the above.* |
|  |  |  |
| **Portal admin** | **Main user details for nib First Choice Portal registration** *The only person who can add staff members to the account* | Name: Click here to enter text.  Business title: Click here to enter text.  Email: Click here to enter text.  Cell phone: Click here to enter text.  *(The cell phone number is only used for security verification at time of registering)* |

Please email all completed forms to: [healthpartner@nib.co.nz](mailto:healthpartner@nib.co.nz)

*If you have any questions, please contact nib on 0800 326 642*