



Australian Government

Department of Health, Disability and Ageing

OFFICIAL

Assignment of Medicare Benefits for Bulk Billing

Frequently Asked Questions

as at 21 May 2026

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Background

- Under the *Health Insurance Act 1973* (the Act), the Australian Government subsidises the cost of health services. This is the legal basis for Medicare benefits to be paid to patients. When patients direct their Medicare benefit payment to their healthcare provider as full payment for a bulk-billed service, this requires an 'assignment of benefit' (AoB). In assigning their benefit, a patient is required to sign an agreement.
- During the COVID-19 pandemic, the Department of Health, Disability and Ageing (the department) issued temporary guidelines to support the AoB process for telehealth services. Under the temporary arrangements in certain situations, patients could verbally consent, as opposed to signing an agreement, to assign a benefit following their consultation with their doctor.
- In January 2023, the Australian National Audit Office released a report which noted that there could be legal risks with undertaking the AoB process verbally, without the requirement for the patient to sign. The Minister for Health, Disability and Ageing responded by asking the department to modernise the process of assigning benefits which will make it easier, safer, and more efficient for everyone.
- The Government has pursued legislative reforms to enable this for bulk billing and simplified billing of privately insured hospital and hospital-substitute treatment.
- Updated AoB requirements commence on 1 July 2026. From this date, the use of previous forms and templates (e.g. [DB4e](#) or [DB020](#)) will no longer be compliant, though they may be modified to suit if a new process is not used.
- From 1 July 2026, the use of verbal AoB for telehealth will no longer be available.
- An assignment of benefit agreement will need to contain the required information as per subsection 65C(4) of the [Health Insurance Amendment \(Assignment of Medicare Benefits and Other Measures\) Regulations 2025](#).
- AoB requirements outlined in this factsheet do not apply to patients accessing health care funded by the Department of Veterans' Affairs.

What are the changes?

The Australian Government has not made any new laws introducing signature requirements for patients to access bulk billing under Medicare. It has been a longstanding requirement under the Act that for bulk billing to occur, a patient (or another person on behalf of a patient as appropriate) must assign their Medicare benefit to the provider in exchange for not incurring any out-of-pocket costs.

When the amendments commence on 1 July 2026:

- Verbal AoB will no longer be available.
- Patients will be able to assign a benefit before (episodic pre-service assignment) or after a service (episodic post-service assignment) is received, so long as patient agreement is made prior to an MBS claim being lodged.
- Practitioners, billing agents, and private health insurers will no longer need to use an 'approved form', so long as agreements include the information required for each type of episodic agreement, as set out in subsection 65C(4) of the [Health Insurance Amendment \(Assignment of Medicare Benefits and Other Measures\) Regulations 2025](#) (the 'data set').
- Practitioners will no longer need to sign the agreement.
- An electronic or physical signature will be required from the patient or responsible person on an AoB agreement. A signature must be identifiable, auditable, and compliant with the [Electronic Transaction Act 1999](#).
- Practitioners will be required to keep a copy of the completed AoB agreements for two years and must provide a copy to the patient upon request.

Why are the changes being made?

In January 2023, the Australian National Audit Office released a report titled [Expansion of Medicare Telehealth Services](#). The report found that there could be legal risks with assigning benefits verbally. The Minister for Health, Disability and Ageing responded by asking the department to modernise the process of assigning benefits for all bulk billed Medicare services.

The following legislative reforms have been pursued to modernise and simplify AoB processes for bulk billing and simplified billing:

- The *Health Insurance Amendment (Assignment of Medicare Benefits) Act 2024* passed Parliament on 2 July 2024 and received Royal Assent on 9 July 2024.
- On 21 August 2025, the *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025* was made by the Governor-General at a meeting of the Executive Council (ExCo).
- The *Health Legislation Amendment (Miscellaneous Measures No. 1) Bill 2025* passed Parliament on 30 October 2025 and received Royal Assent on 4 November 2025 for implementation on 1 July 2026.

Medicare Benefits Schedule

Modernising the assignment of benefit process for bulk billed services

– Frequently Asked Questions

Last updated – 21 May 2026

Where can I find more information?

For more information on the process of improving the assignment of benefit, please refer to: Improving the assignment of benefit process - Australian Government Department of Health, Disability and Ageing.

For enquiries or further details regarding the Assignment of Benefit (AoB) project, please reach out to: AssignmentofBenefit@health.gov.au

Frequently asked questions

Can I use the DB4e or DB020 forms after 1 July 2026?

No. From 1 July 2026, the existing 'approved forms' ([DB4e](#) and [DB020](#)) will no longer meet the requirements for a valid Assignment of Benefit (AoB) agreement.

Under the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025, the concept of an 'approved form' is replaced with a mandatory information set (referred to as a *data set*) that must be provided to, and agreed by, the assignor.

Importantly, there is no prescribed template or mandatory form. An AoB agreement may be presented in any format (paper or electronic), provided it includes all the information required to be given to the assignor under the regulations and is agreed to in writing. Verbal agreements are not sufficient.

If all required information is present and the assignor has agreed, the document will constitute a valid record of assignment of Medicare benefit, regardless of its format.

Services Australia will make example templates available on its website to assist providers; however, use of those templates is optional, not mandatory.

A completed AoB agreement must be retained by the provider (electronically or in hard copy) for two years after the claim is made and may be requested as evidence for compliance or audit purposes.

Will the DB4e be discontinued for Post-Assignment after 1 July 2026?

Yes. As of 1 July 2026 the agreement previously evidenced through the use of the AoB approved form ([DB4e](#) or [DB020](#)) will no longer be required.

Instead, the agreement will need to contain the required 'data set' as per subsection 65C(4) of the *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025* to allow the patient to inform their decision. Although there is no longer an 'approved form' Services Australia will make a template publicly available.

Please see the Services Australia website for more information.

Do adults accompanying children have to be the parents or a legal guardian to be able to sign for a minor?

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.

Persons employed by the medical practitioner rendering the medical service cannot be the 'assignor' as there is a perceived financial conflict of interest. If those persons are the parents or carers of the patient however, it would be considered acceptable for them to assign on the child's behalf.

Practices should consider that the person who makes the assignment is being presented with health-related information about a patient (i.e. the new 'data set' information). Protecting the patient's privacy is important and should be taken into account in all transactions.

What if the medical service ends up being different from what is booked?

If the medical service provided is different from what has been assigned under an episodic pre-service agreement, a new AoB agreement will need to be obtained which reflects the service rendered. If it is known that the service will be different to what has been booked before the service is provided, then a new pre-service agreement could be sought from the patient. Otherwise, a post-service episodic AoB agreement should be obtained from the patient.

The 'data set' required for a post-service AoB agreement is different to a pre-service AoB agreement. For all post-service agreements, the MBS item number/s must be recorded in the agreement.

Providers should consider whether the use of pre-service assignment is compatible with their workflow and operating environment. If service details vary frequently between booking and delivery, providers should consider if post-service episodic assignments are more suitable.

What if the service ends up being different from what was on the pre-assignment agreement?

Pre-assignment agreements are established by using a category of services that could be within scope. This is categorised through the 'basic service description,' which is intended to be more meaningful for assignors while allowing providers to update MBS items without requiring additional assignment agreements.

If the rendered service is inside the scope of the basic service description, then the agreement remains valid.

If the rendered service is outside the scope of the basic service description, then the agreement is no longer valid and a post-service assignment agreement with correct information is required.

Can patients provide their assignment verbally?

Patients (or their assignor) can verbally assign their benefit for telehealth services until 1 July 2026. Where verbal assignment is obtained, it must be documented by the provider by completing an electronic 'approved form' (e.g. DB4E), and the patient must be provided with a copy of the completed form.

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*.

Will there be transitional arrangements in place?

Transitional arrangements will be in place for **pathology services only**.

Where an AoB agreement exists on a request for pathology tests that was issued prior to 1 July 2026, it can still be used for up to 12 months from the date of issue.

For all other services, where an AoB agreement is required to support a manual claim, or a resubmitted claim made from 1 July 2026, for services rendered before 1 July 2026, the new AoB agreement data set will be required to evidence an assignor's agreement.

What constitutes a 'signature'/accepted assignment of benefit?

From 1 July 2026, providers will no longer be required to sign an agreement. Patients (or their assignor) will be required to sign an agreement to evidence their consent to assign their Medicare benefit. A physical or electronic signature is acceptable.

Where an electronic signature is used, it must meet the requirements of the *Electronic Transactions Act 1999* Part 2, Division 2 Section 10. It must:

- reliably identify the assignor
- reliably indicate assignors' agreement (by requiring an action)
- meet all other privacy and information technology requirements.

What if new digital processes cannot be implemented by 1 July 2026?

From 1 July 2026, medical practitioners will be **legally required** to use new AoB processes and agreements to secure a compliant assignment before related bulk-billed Medicare claims can be made. The changes under the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024* allow for digital options, but do not require them.

If digital solutions are not available from 1 July 2026, paper forms can still be used. Completed AoB agreements are required to be retained by the provider for two years, and a copy provided to the patient if requested. However, they **are not required** to be submitted to Services Australia, except for manual claims.

Templates for AoB agreements will be available from the Services Australia's website. Alternatively, providers can develop their own agreement (i.e. create a Microsoft word document) based on the requirements outlined in the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.

Copies of completed AoB agreements may be required as evidence of a legally compliant bulk-billed service as part of compliance activities.

What if the patient does not agree to assign their Medicare benefit?

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.

In a pre-assignment scenario, the patient may choose not to assign their Medicare benefits initially, opting instead to make this decision after services have been provided. If the patient ultimately declines to assign their Medicare benefits, they will be responsible for the out-of-pocket payment.

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](#)

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

Any pathology referral forms issued prior to 1 July 2026 will remain valid for AoB purposes for up to 12 months. However, any referrals issued after that date must comply with the new AoB requirements.

If referral 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 referral, or the receiving pathologist could seek a patient's post-service assignment agreement.

The information required for pathology (excluding group P9) assignment of benefit agreements from 1 July 2026 include the following:

Pre-assignment	Post-assignment
Patient Name	Patient Name
Date of assignment	Date of assignment
Assignment type (i.e. pre or post)	Assignment type (i.e. pre or post)
Is the assignor the patient – yes/no	Is the assignor the patient – yes/no
Date of specimen collection	Date of specimen collection
Statement of assignor's agreement for all services on the referral and to capture pathologist determinable services	Details of the professional (as per Section 54 of the <i>Health Insurance Regulations 2018</i>)
Description of the service	MBS item/s

A detailed outline of the requirements for the pathology AoB agreements can be found in the *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025*.

Scenario 1 – Referral form obtained prior to 1 July 2026 and used after the commencement date

Any pathology referral forms obtained prior to 1 July 2026 will remain valid for AoB purposes for up to 12 months.

Scenario 2 - Referral form obtained after 1 July 2026, using the old, printed referral forms (notepads), and used after the commencement date

For scenarios where a hard-copy pathology referral form from the printed notepad is obtained after the commencement date of the new arrangements, the provider or collection centre must add the missing data sets at the point of specimen collection. In most cases this will be the addition of:

- Assignment type (pre- or post-)
- Is the assignor the patient? (yes/no)

In some cases, the following data sets will also need to be added:

- Details of the professional (as per Section 54 of the *Health Insurance Regulations 2018*)
- MBS item/s

Scenario 3 – Referral form obtained after 1 July 2026 and used after the commencement date

Any referrals issued after the commencement date must comply with the new AoB requirements. If the provider chooses to separate the AoB agreement from the referral, the agreement must also comply with the new requirements.

The AoB agreement, whether embedded on or separate from the referral, can be completed electronically or via hard copy.

Will basic service description groups be included in the MBS XML for easier loading?

The XML fee file which software providers are familiar with will not contain the basic service description classifications for pre-assignment agreements.

However, the 'Health Insurance Regulations 2018 - Basic Service Description for Assignment of Medicare Benefit' document will be uploaded to the downloads section on MBS Online, where providers are accustomed to finding the XML fee file

(<https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads>).

The document will be available as an XML and CSV.

The Basic Service Description will be updated quarterly in line with regular updates to the XML fee file (being 1 January, 1 July, 1 March, and 1 November).

How does episodic pre-service assignment function?

From 1 July 2026, patients can be offered the option to assign their Medicare benefits in return for being bulk billed (and face no out-of-pocket costs) before their appointment. This could be done when patients check in for their appointment, when they book a service by using online booking applications, check-in kiosks, or other mechanisms.

Although the specific service may not always be known before a service is rendered, a basic service description will be required on pre-service assignment agreements to inform a patient's decision as to whether to assign their Medicare benefit. If the actual service rendered differs significantly from the service described in the pre-service assignment agreement (i.e. falls outside the agreed basic service category), then a post-service AoB will need to be completed after the medical service. This could be obtained electronically or in hard copy.

What happens if a patient sees a different practitioner on the appointment day despite completing a pre-assignment?

If the rendering practitioner differs from the practitioner listed in the pre-assignment agreement, it is necessary to complete an updated pre-service assignment before the service (if known), or a post-service assignment agreement with the details of the practitioner who did deliver the service.

Details of the 'data set' are outlined in subsection 65C(4) of the *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025*. If the information in the AoB agreement does not match the claim, it does not meet legal requirements for that claim.

Is it possible to approve pre-assignments in advance for planned treatments?

Yes. However, the associated claim can only be submitted after the service has been rendered. If the service is not provided or is changed (e.g. the date of service changes, or the service or the practitioner changes), the assignment becomes void and a new AoB agreement is required.

Can the new dataset be used before 1 July 2026, and is a Notice of Integration (NOI) required?

Yes. Provided the requirements of both current and new legislation are met, this is acceptable.

Regarding the NOI and connections to Services Australia's systems, further information can be obtained by contacting Services Australia directly.

The best way to stay up to date on software issues is to be signed up to access Services Australia's Health Systems Software Developer Portal. If you are not signed up, information is available at - [Get started as a software developer - Health professionals - Services Australia](#) and [Home | Health Systems Developer Portal](#)

What will be the process for handling 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.

What steps should be taken if a patient is unable to sign?

If a patient is unable to sign an AoB agreement, an assignor (i.e. parent, partner, carer, relative, person with power of attorney or friend) could be asked to sign the agreement. Persons employed by the medical practitioner rendering the medical service cannot be the 'assignor' as there is a perceived financial conflict of interest. If those persons are the parents or carers of the patient, however, it may be considered acceptable for them to assign on the child's behalf.

Practices should consider that the person who makes the assignment is being presented with health-related information for a patient. Protecting the patient's privacy is important. If the patient or an assignor is unable to sign an agreement in person, an electronic signature could be obtained.

Without a patient or assignor's signature, an AoB agreement is not complete, and a bulk-billed claim should not be made.

What is the assignment of benefit process for public patients in public hospitals?

Public services provided to public patients are funded under the National Health Reform Agreement (NHRA). All components of an episode of public patient care must be provided free of charge and no claims should be made against the Medicare Benefits Schedule (MBS).

If patient's have elected to be private patients, they would assign benefits for bulk billed services the same way as any other setting. This could include pre-service assignment/s if the details are known (e.g. dates, kinds of services, providers, etc). This could be included with private election or at patient check-in, if appropriate.

If a pre-service assignment is not practical, then post-service assignment should be used. This would be similar to the process before 1 July 2026, requiring the DB4E form, for example.

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.

The department is working to finalise regulations to support enduring AoB for patients who are registered in MyMedicare or receive services from an Aboriginal Community Controlled Health Organisation (ACCHS) or Aboriginal Medical Service (AMS). Enduring AoB will require an agreement to be signed once (by a patient or their assignor), for ongoing and future services from a preferred clinic/practice.

The use of an enduring assignment will have a post-service notification requirement. This will require providers to send a notification to patients after a related service. Enduring assignment will commence in 2027.

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All information in this publication is correct as at May 2026