

Changes to the requirements for the Assignment of Medicare Benefits: What you need to know

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Significant changes to the Assignment of Medicare Benefits (AoB) process take effect on 1 July 2026. These changes affect all practitioners who intend to bulk bill their patients. For an initial 12 months following the commencement of these changes, there will be a 12-month transition period, during which the Department of Health, Disability and Ageing will take an educational approach to compliance. Practices can use this time to implement the new requirements at a manageable pace. Understanding your obligations now will help ensure your practice is ready.

What is changing and why?

The Assignment of Medicare Benefits is the legal process by which a patient assigns their right to a Medicare benefit to a medical provider (for bulk billing) or a private health insurer or approved billing agent (for simplified billing).

The existing process, which has remained largely unchanged for decades, is being modernised. Services Australia says that this is designed to improve accuracy, patient transparency and payment integrity.

These changes affect both bulk billing and simplified billing arrangements. If you bulk bill your patients, go to [Summary of key changes to the assignment of benefits for bulk billing](#). If you bill through a private health insurer or approved billing agent, go to [Changes to the assignment of benefits for simplified billing](#).

Summary of key changes to the assignment of benefits for bulk billing

The key reforms in relation to practitioners who bulk bill are as follows:

1. Verbal AoB will no longer be accepted (note: verbal AoB remains available during the 12-month transition period – see below).
2. While patients can assign a benefit before or after a service is provided, it must be done before the MBS claim is lodged.
3. Practitioners will no longer need to use an 'approved form' (or any other prescribed template), so long as the agreement includes information stipulated in subsection 65C(4) and subsection 65D of the [Health Insurance Amendment \(Assignment of Medicare Benefits and Other Measures\) Regulations 2025](#). See Table 1 for a summary of the information required.
4. Practitioners will no longer need to sign the agreement.
5. 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](#).
6. 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.

Note: the Government has announced a 12-month transition period for the bulk billing changes. During this time, DoHDA will take an educational approach to compliance. See [Preparing for the changes for bulk billing](#) below for details.

Table 1.

Assignment Type	Pathology (excluding Group 9)	Diagnostic Imaging	All other MBS services (including Group P9)
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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 	<ul style="list-style-type: none"> • Patient name • Date of assignment • Assignment type (pre-assignment) • Is the assignor the patient – yes/no • Details of the professional • Date of service • Basic service description
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 	<ul style="list-style-type: none"> • Patient name • Date of assignment • Assignment type (post-assignment) • Is the assignor the patient – yes/no • Details of the professional • Date of service • MBS item/s

* statement captures pathologist determinable services

statement captures DI services as per Section 16B of the HIA (i.e. services deemed required by rendering professional

Source: Australian Government Department of Health, Disability and Ageing, Assignment of Medicare Benefits for Bulk Billing – Frequently Asked Questions: <https://www.health.gov.au/resources/publications/assignment-of-medicare-benefits-for-bulk-billing-frequently-asked-questions>

Other requirements for the assignment of benefits for bulk billing from 1 July 2026

From 1 July 2026, patients can be offered the option to assign their Medicare benefits in return for being bulk billed before their appointment. This could be done when patients check in for their appointment at the reception desk or using check-in kiosks, or when they book a service using an online booking engine. If the actual service rendered differs significantly from the service described in the pre-service assignment agreement or if the patient ends up consulting with a different medical practitioner, then a post-service AoB will need to be completed after the medical service.

Multiple services may be included on the same AoB agreement, provided they are provided by the same practitioner on the same day. Multiple services provided by different practitioners (even if they are at the same clinic) require separate AoB agreements.

While medical practitioners will be required to use updated processes and agreements from 1 July 2026, they will not be required to submit these to Services Australia (except in the case of manual claims). Likewise, practitioners are not required to use digital solutions and may instead opt to use their own paper forms. Services Australia will make templates available.

If patients do not consent to assign their Medicare benefit, then they cannot be bulk billed.

If the patient is unable to sign an AoB agreement (because of physical disability or a lack of decision-making capacity), then an assignor (i.e. parent, partner, carer, relative, person with power of attorney or friend) could be asked to sign the agreement. An assignor cannot be the medical practitioner or a person employed by the medical practitioner.

Practitioners must also keep records sufficient to demonstrate a valid AoB occurred. Copies of completed AoB agreements must be retained for two years, and must be provided to patients or Services Australia, on request.

Preparing for the changes for bulk billing:

You will need to consider how your practice will implement the new AoB processes. This includes deciding when patients will be asked to assign their benefit – for example, at the time of booking, on arrival at reception or a self-check-in kiosk, during the consultation, or afterwards. You will also need to determine how patients will assign their benefit, whether through paper-based methods or electronically (via email or SMS).

During the 12-month transition period, verbal assignment of benefit will remain available for all bulk billed patients while practices implement updated processes. From 1 July 2026, patients registered with MyMedicare, residents of aged care homes, and patients of Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services will also be able to make an enduring assignment of benefit for GP bulk billed services.

Finally, ensure that patient contact details are current and that you understand each patient's preferred method of communication, particularly if you intend to use electronic assignment methods.

Changes to the assignment of benefits for simplified billing

In addition to the changes to AoB for bulk billing, there are also changes to how Medicare benefits can be assigned to a private health insurer (PHI) or billing agent when claiming for hospital treatment.

Where there is a private health insurance benefit associated with a Medicare benefit, simplified billing enables the Medicare benefit to be paid to the PHI or approved billing agent, and they process the Medicare and PHI benefits to the final beneficiary (such as the medical provider).

There are two pathways for simplified billing assignments:

1. **Implied assignment** applies automatically where there is a qualifying arrangement in place between the practitioner (or hospital or organisation) and the PHI. Where this applies, no manual signatures or patient approvals are required for the assignment. See [Services Australia's FAQs](#) for more information.
2. **Requested assignment** applies where no such arrangement exists. This requires a written request facilitated by the practitioner, hospital or organisation, which the patient must agree to in writing (including via electronic signature). The request must contain specific information, including: the patient's details, the insurer or approved billing agent to whom benefits are assigned, a description of the hospital treatment or hospital-substitute treatment, the names of health professionals covered, the location of service, and the date of admission or service.

Importantly, a single assignment request can cover all services within an admission – including surgery, anaesthesia, pathology and diagnostic imaging – provided the request is sufficiently detailed. Complications arising from the original treatment are automatically covered.

Claims declaration – a new requirement for simplified billing

From 1 July 2026, every Medicare claim for an assigned benefit (where the benefit is paid to a private health insurer or approved billing agent rather than the patient) must include an AoB declaration. The claimant must attest that assignment requirements have been satisfied. Claims submitted without this declaration will be rejected.

The declaration wording is straightforward – for example: "This claim for Medicare benefits has been assigned under implied assignment" or "...under requested assignment" – but it is a legal requirement that cannot be overlooked.

The importance of informed financial consent

Before an AoB for simplified billing can occur, the patient (or eligible assignor of benefits) must understand the financial implications of assigning their Medicare benefit to a private health insurer or approved billing agent, who they are assigning it to, and which benefits will be assigned.

Therefore, informed financial consent (IFC) underpins a valid implied or requested assignment. IFC is the process of ensuring a patient (or other eligible assignor) is given clear, accurate and timely information about the expected costs of their care before they agree to proceed with treatment and before they assign any Medicare benefits associated with that treatment.

Record-keeping obligations for simplified billing

All parties relying on simplified billing assignments must keep records sufficient to demonstrate a valid assignment occurred. This includes a copy of the signed assignment request. Records must be retained for seven years from the date of creation.

Practical steps to prepare for simplified billing changes

- Identify which pathway applies to the services you typically provide – implied or requested.
- Review your existing admission and informed financial consent forms to incorporate requested assignment requirements where

needed. These can be embedded in existing documents rather than created as standalone forms.

- Ensure your billing software is updated to include the AoB claims declaration before 1 July 2026.
- Confirm with hospitals whether they are facilitating assignment requests on admission, so you know whether you need to obtain a separate assignment for your services.
- Keep records of all assignments, consistent with the seven-year retention requirement.

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