

Nurse Practitioner capitation funding access

Please complete the below information and return to Libby Harper, Practice Support Administrator libby.harper@pinnacle.health.nz.

Practice name	
Legal entity	
Practitioner name	
MCNZ number	HPI number
Email address for Pinnacle notific	cations
Applicant checklist (please tick):	
I am registered under the authority under the Act	e Health Practitioners Competence Assurance Act (HPCA) with the relevant
☐ I hold a current Annual P	ractising Certificate (APC) with the relevant authority
☐ I am working within my s	cope of practice as part of a general practice team
	imployed at a general practice that enrols patients for funding under the terms covider Agreement – First Level and Other Services" between above named legal porated.
☐ The accompanying 'Pract	citioner Payment Form' has been completed and signed.
Declaration, the above informati	ion is true and correct to the best of my knowledge.
Practitioner signature:	Date:
Business Owner/Practice	Manager to complete
I confirm the above details and a	ttached bank account details are correct
Name	Role
Signature	Date

Practitioner payment method

Confirmation of bank account details for any patient funding (i.e. capitation and/or service claims payment in relation to patients under this practitioner's care, in the practice named below).

Practitioner name
Practice name
Please check bank account details with your practice manager and include copy of deposit slip OR bank record with account name, bank name and account number.
Full account name:
Account number: (right-align all account numbers. e.g. record an 02 suffix as 002)
Bank Branch Account Suffix
Practitioner signature: Date:
Fmail remittance advices to: