



**\*Only to be completed if bank account details have never been submitted or differ  
From those previously submitted\***

# EFT Payment Authorisation Form

Panel No: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Tax Registration Number: \_\_\_\_\_

E-mail remittance address: \_\_\_\_\_

Phone No: \_\_\_\_\_

**I HEREBY AUTHORISE THAT ALL FUTURE PAYMENTS DUE FROM THE  
DEPARTMENT OF SOCIAL PROTECTION BE PAID DIRECT TO THE BANK  
ACCOUNT DETAILED BELOW**

## BANK ACCOUNT DETAILS

Name of Account Holder: \_\_\_\_\_

Name of Bank: \_\_\_\_\_

Address of Bank Branch: \_\_\_\_\_

Bank Branch Sort Code

--	--	--	--	--	--

Bank Account Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--

BIC/SWIFT Code

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

IBAN Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Doctor's Signature)*

Name: \_\_\_\_\_  
*(BLOCK LETTERS)*

**For Office Use only**

Input: \_\_\_\_\_ Approved: \_\_\_\_\_