

ancillary providers guide

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The intended use of this guide is to support recognised ancillary and/or allied health providers only.

Recognition criteria can be found on our website
<http://www.gmhba.com.au/contact-us/provider-registration/ancillary>

It is GMHBA Limited's expectation that providers adhere to all HICAPS or HealthPoint agreements and code of ethics and requirements relevant to their discipline's governing body.

Hospital and medical providers should refer to relevant Australian, state, and territory government regulations and guidelines as well as any relevant active agreements.

benefits.

Treatment to be provided by Recognised Providers

Benefits are payable only where treatment is provided by a Recognised Provider. Frank Health Insurance recognises the following providers:

- a. General Treatment Providers who are:
 - i. In independent Private Practice,
 - ii. For each relevant class of service or treatment, satisfy all applicable recognition criteria with Medicare or other Frank Health Insurance approved industry body such as the Australian Regional Health Group and Australian Health Practitioner Regulation Agency (AHPRA);
 - iii. Approved by Frank Health Insurance in its absolute discretion

Providers who Fail to meet Recognition Requirements

Frank Health Insurance will decline to pay Benefits in respect to any claim where Frank Health Insurance has reasonable grounds to believe that at the time the services were provided:

- a. By a General Treatment Provider who is not in independent Private Practice or does not satisfy an applicable recognition criterion

Benefit Reduction

Benefits may be reduced in the following circumstances:

- a. Where the charge is lower than the Benefit that would otherwise have been payable, the Benefit shall be reduced to the amount of the charge;
- b. Where a Benefit is claimable from

another source for the same service, the Frank Health Insurance Benefit may be reduced by the amount claimable from the other source, and

- c. Where in the opinion of Frank Health Insurance the charge is higher than the Provider's usual charge for the service, Frank Health Insurance may assess the claim as if the Provider's usual charge had been applied.

Providers Treating Themselves, Family Members, and Business Partners and Family

- a. Subject to b), Benefits are not payable for treatment rendered by a provider to:
 - i. The provider's Partner, Dependants, or business partner, or
 - ii. Family members of the provider and the providers business partner including: wife/ husband, brother/ sister, children, parents, grandparents and grandchildren, or
 - iii. The provider themselves,
 - iv. The Partner or Dependants of the provider's business partner, or
 - v. Any other person not independent from the practice.
- b. Frank Health Insurance may at its discretion pay Benefits in these cases:
 - i. Where it is satisfied that the charge is a legally enforceable debt, or
 - ii. In respect of the invoiced cost of materials required in connection with any treatment.

Benefit Assessment

Frank Health Insurance may request information from a Policyholder or their health service provider prior to or after the payment of Benefits. Information requested will be directly related to a claim where the Policyholder has made a declaration requesting Benefits be paid to the Policyholder or their health service provider.

Such information may include but is not limited to:

Invoices;

- a. Receipts;
- b. Treatment Plans;
- c. Prescriptions;
- d. Medical/Patient records and clinical notes.

Benefit Restitution

Frank Health Insurance may seek restitution where:

- a. A claim contains false or misleading information;
- b. A claim is incorrectly assessed;
- c. A claim is paid after the termination date of the Membership;
- d. Information is received after the claim has been paid which establishes that the Benefit should not have been paid.

Claims Fraud

Frank undertakes audit activities in order to protect members' assets and contain costs. As we have online extras claiming with no need to send in receipts a member will need to keep their receipts somewhere safe for two years just in case our Audit team wants to check up.

From time to time, in the general interest of members, a Frank representative may contact you with a request for assistance to monitor costs – whether relating to benefits paid or charges raised by health care providers. Your co-operation with such requests is critical to our cost containment efforts, and will be treated in a completely confidential manner.

Frank reserves the right to take the following actions against any member or persons where improper, fraudulent or indiscretion occurs whilst making health insurance claims.

Actions that may be taken are:

- Suspension of electronic claiming for the period of time determined by Frank depending on the severity of the incident
- Restitution (voluntary or negotiated)
- Refer matters to relevant regulatory authority
- Prosecution

Limitations on Consultations provided on the Same Day

Frank Health Insurance has limitations on Consultations provided on the same day.

- a. More than one consultation and/or treatment type per day has been claimed and performed by the same provider within a group of chiropractors (excluding X-Ray), acupuncturists, osteopaths, physiotherapists, myotherapists and if eligible remedial massage therapists.

Recognised Providers

Frank Health Insurance will only pay Benefits for General Treatment where it is provided:

- a. By or on behalf of a Recognised Practitioner in Private Practice;

- b. On premises registered with Frank Health Insurance, unless otherwise approved; and
- c. Where services are provided face to face or as a recognised telehealth service as approved by Frank Health Insurance.

For the avoidance of doubt, Frank Health Insurance will not pay Benefits for treatment provided by someone who was not a Recognised Practitioner at the time that person provided the treatment. Frank Health Insurance has sole and absolute discretion in determining if someone becomes or remains a Recognised Practitioner and for which of their treatments Frank Health Insurance will pay Benefits. Frank Health Insurance may choose to “de-recognise” someone from being a Recognised Practitioner for reasons including, but not limited to, fraudulent behaviour or the agreement governing the relationship between Frank Health Insurance and that person comes to an end.

Obligations of recognised providers

A Recognised Provider must:

- a. Undertake in a diligent and professional manner the provision of treatment, goods or services to Members and maintain the quality of the treatment, goods or services;
- b. Comply with each law, and each requirement arising from a law, and hold and maintain every required licence, permission and registration necessary to provide treatment, goods or services to Members including as required by the Private Health Insurance (Accreditation) Rules;
- c. Conform to the general standards required by all relevant regulatory bodies;
- d. Not act contrary to the interests of Frank Health Insurance or in a way which brings Frank Health Insurance into disrepute;
- e. Promptly advise Frank Health Insurance of any event or occurrence that the Recognised Provider is aware of which may reasonably be expected to lead to a complaint about Frank Health Insurance from any person;
- f. Not provide information to Frank Health Insurance which is false or misleading;
- g. Not mislead or deceive Frank Health Insurance in any other manner including by failing to provide true and full information at any time;
- h. Not act or attempt to act improperly so as to:
 - i. Obtain an unfair advantage for yourself or another person; or
 - ii. Cause loss or damage to Frank Health Insurance; and
 - iii. Only provide a treatment, good or service to a Member while engaging in Private Practice if they do not otherwise make that treatment, good or service available to persons while not engaging in Private Practice;

Agreements with General Treatment Providers

Frank Health Insurance may, from time to time, enter into agreements with providers of General Treatment. The Benefits that apply under these agreements may differ from, and will take precedence over, those shown in general information about our Products. Lists of providers of General Treatment with whom Frank Health Insurance have agreements are available on

ancillary claiming criteria.

our website.

Invoices and Receipts

Practitioners and businesses must include the below information on all invoices or receipts:

- The name and address of the member
- The date of service
- A description of the service provided that aligns with the Private Healthcare Australia (PHA) endorsed schedule (if applicable)
- Itemised detail of each item or service
- Provider's full name, company name or trading name
- A valid ABN and/or ACN as applicable
- The location the service was provided
- A valid provider number (including but not limited to):
 - Services Australia provider number for the location
 - ARHG Provider Number
 - Health Fund Issued Provider Number

Where the client/member address is not included on the invoice/receipt the health fund member is required to complete a claim form.

- Benefits are only payable on itemised receipts.
- Receipts which have been altered in any way will not be accepted.
- Providers are required to reissue any receipts or endorse any alterations.

Extras Claims | Electronic Claiming

When a member has Frank extras cover they can use their Frank member card to claim electronically on-the-spot (if you have

an electronic claiming machine). After the service has been provided, the member card will be tapped at or swiped through the terminal, the claim details entered and the members claim will be processed electronically. Once your claim is authorised by Frank, the member simply pays any difference between the full fee for the treatment and the amount paid by Frank.

If there is an unexpected rejection of the claim at the point of service, you should check the receipt for the rejection reason. If you are unable to identify the issue at the time of the service taking place please contact Team Frank.

Online Extras Claims

If you do not have an electronic terminal, the member will need to pay your account in full and then submit a claim via the Frank app or online Member Area. Members can either claim without submitting a receipt or upload a copy of the receipt at the time of claiming. If the member doesn't include the receipt at time of claiming, they will need to keep it for 2 years and send to Frank if their membership claims are audited in this time.

Manual Extras Claims

In some situations a member may not be able to claim online, and they'll need to submit their claim manually to Frank via email. Accounts must have been paid before they can be submitted for claiming.

To submit a claim manually, Frank needs the following information:

- The fully itemised health care account/s, and the receipt/s.

Extras services purchased over the internet

Benefits will be paid for optical items purchased over the internet from Australian providers where a prescription is provided.

Benefits for services or treatment received overseas are excluded.

Individual telehealth consultations

One on one Telehealth Consultations are covered with a Frank recognised provider, for services as approved by Frank. A list of recognised modalities is available and may be changed periodically. Telehealth services are considered a substitutional service, and meet the requirements, to what would otherwise be undertaken as a standard face to face consultation, are covered in accordance with industry association guidelines by using appropriate telehealth delivery services that satisfy the requirements of the patient/condition to be treated. Telehealth consultations may not be appropriate for all situations. Benefits are subject to your level of cover, waiting periods and annual limits or sub limits.

Doctors Letter of Recommendation

The following services require a Doctor's Letter of Recommendation in support of claims:

- a. Blood Glucose Monitor, and
- b. Quit Smoking Programs

Physiotherapy

Consultations must be for a minimum of 15-20 minutes to qualify for one-on-one physiotherapy benefits.

Group sessions must not exceed six

participants, the provider must be readily accessible during the entire course of a session, and the session will be of sufficient length to allow feedback and adjustment for each participant to occur.

For group physiotherapy, an individual assessment by a physiotherapist must have been previously provided.

Occupational Therapy

A professional Treatment that is:

- a. Approved by Frank Health Insurance; and
- b. Provided during a one on one Consultation with a person who is recognised by Frank Health Insurance as an Occupational Therapist.

Optical

Optical claiming includes prescription glasses (frames and lenses) and contact lenses.

Frank Health Insurance define optical as the provision of a sight-correcting appliance upon prescription by a recognised provider.

Where frames are purchased separately from prescription lenses, the claim should be submitted by the member to the fund for manual assessment on completion of the prescription lenses being fitted. These claims must not be processed via HICAPS or HealthPoint.

Orthotics

Where covered, benefits can only be claimed on orthotics if they are custom-made (from a cast or mould taken by you) by a podiatrist or orthotist in a private practice.

Weight management programs

Weight management benefits are claimable towards the costs or fees associated with membership to a weight management provider. Benefits are not payable towards the purchase of food and/or dietary supplements or exercise components. Approved weight management providers are Jenny Craig, Weight Watchers and Fernwood Food Coaching.

exclusions.

No Benefit Payments unless permitted by Legislation

Irrespective of anything else contained within this Guide, Frank Health Insurance will not pay a Benefit to Members for a treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules, unless it has been permitted to do otherwise under any legislative or regulatory instrument, or in any condition of registration.

In addition to the services excluded from a members cover, they cannot claim for the following:

- Benefits are only payable on itemised and original account/s. Accounts which have been altered in any way will not be accepted. Providers are required to re-issue any accounts or endorse any alterations.
- Natural remedies (includes Modifast & Optifast) & food supplements
- Dental procedures carried out and charged direct to the member/ dependant by a dental mechanic, other than an advanced dental technician.
- A range of dental procedures when provided on the same day e.g. a filling on a tooth that has been removed.
- Dental procedures where a limit on the number you can have has been exceeded.
- Dental procedures unless tooth identifications (ID) are supplied by the provider.
- Services/treatment for which the member and/ or dependant has a right to claim damages or compensation from any other person or body.
- Treatment where the member and/or dependant is eligible for free treatment under any Commonwealth or State Government Act.
- Services/treatment rendered more than 12 months prior to the date of claiming.
- Services/treatment which is not covered by the membership and/or is rendered while the membership is in arrears or is suspended.
- Services/treatment rendered by a practitioner not in private practice and/ or not recognised by bodies approved by Frank.
- Hiring of equipment (unless otherwise stated).
- Services are not rendered face to face with exception of approved Telehealth services
- Foot orthotics unless they are custom-made and provided by a registered podiatrist or orthotists.
- Benefits for lifestyle related services that primarily take the form of sport, recreation or entertainment.
- Benefits, payable under a hospital or extras cover shall not exceed the fees and/ or charges raised for any treatment and/ or services covered for benefits under the relevant cover, after taking into account benefits paid from any other source.
- Benefits for services on treatment received overseas.
- Travel vaccinations not listed on the approved Travel Vaccinations list.
- Extras services that the member is entitled to claim a Medicare rebate for.
- Cosmetic services or treatment rendered by a practitioner.

Dental Exclusions

* Only Frank Simple Extras, Everyday Extras and More Extras do not pay a benefit on these item numbers.

019	Letter of referral	384	Repositioning of displaced tooth/teeth
018*	Written report (not elsewhere included)	394*	Surgery for osteomyelitis
026	Cone Beam Volumetric Tomography - scan acquisition (per visit)	438*	Hemisection
044	Collection of specimen for pathology examination	664	Fitting of bar for denture - per abutment
047	Saliva screening test	666	Prosthesis with metal frame attached to implants - per tooth
054	Mucosal screening	668	Fixture or abutment screw removal and replacement
059	Comprehensive head and neck cancer examination and risk assessment	669	Removal and reattachment of prosthesis fixed to implant(s) - per implant
061	Pulp testing	689*	Provisional implant
085	Electromyographic recording	711 - 769	Dentures and denture related items
086	Electromyographic analysis	778	Inlay for denture tooth
087 - 091	Cone Beam Volumetric Tomography analysis and/or interpretation	779*	Surgical guide for an immediate denture
119	Bleaching, home application - per arch	915	After-hours callout
122	Topical remineralizing and/or cariostatic agents, home application - per arch	916	Travel to provide services
123	Concentrated remineralizing and/or cariostatic agents, application - single tooth	926	Individually made tray - medicament(s)
131	Dietary advice	927	Provision of medication/medicament
141	Oral hygiene instruction	941	Local anaesthesia
142	Tobacco counselling	944	Relaxation therapy
165	Desensitizing procedure - per visit	945	Low level laser therapy - per appointment
237*	Guided tissue regeneration - membrane removal	948	Dental acupuncture - per appointment
238*	Periodontal surgery for crown lengthening - per tooth	949	Treatment under general anaesthesia/sedation
332*	Ostectomy - per jaw	985	Repair/addition - snoring or sleep apnoea device
375*	Surgery to salivary duct	990	Treatment not otherwise included (specify)
376*	Surgery to salivary gland	999	GST

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frankhealthinsurance.com.au

[contact team frank](#) | [webchat](#) | call 1300 437 265

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