

# NDIS Service Provider Request Form



**Date:** / /      **Provider:** 4050007361      **Organisation:** Geelong Rehabilitation Centre  
**Contact:** Geelong Rehabilitation Centre      **Email:** receptionbelmont.grc@gmail.com

PARTICIPANT HAS APPROVED CONSENT TO ENGAGE WITH PROVIDER

Participant's Name			
DOB		Phone	
Address			
Preferred Contact #		Disclose Phone calls from SSC	
Email		Preferred Contact Time	
Disability Type		NDIS #	
Plan Start Date		Plan End Date	

ALTERNATE CONTACT / NEXT OF KIN			
Name		Relationship	
Phone #		Email	

SERVICE REQUEST DETAILS			
Service Required			
Start Date		End Date	
Frequency		Duration	
Relevant Line Items			
Fund Management Type			

# NDIS Service Provider Request Form



Further Details	
Health Conditions	
Alerts - Pets, Risks, Smoking etc	
Behaviours of Concern	

PLAN MANAGER DETAILS (where applicable)	
Nominated Plan Manager	
Provider Email	
Approval of Invoice payment will be completed by:	
<input type="checkbox"/> Participant/Nominee <input type="checkbox"/> Support Coordinator	

SUPPORT COORDINATOR DETAILS			
Name		Mobile	
Email			