

Important Information

- Membership contributions must be up to date.
- HCF reserves the right to exclude from payment or to recover any benefits payable where, in our opinion, there is an entitlement to claim compensation or damages from another source.
- Claims must be lodged within two years of the goods and/or services being provided.
- A claim may not be made for any goods and/or services until they are actually provided.
- Goods and/or services received overseas are not claimable.
- Benefits are only payable for goods and or services given by HCF recognised providers in private practice.
- Benefits are not payable for ancillary services that you are claiming or intend to claim from Medicare.
- Please attach original receipts/accounts (not photocopies) to the claim form which should include:
 - the service provider's/supplier's full details on official stationery.
 - the full name and address of the recipient of the services.
 - the item number(s) and or description(s) of the services.
 - the cost of each service.
 - the date of each service.
 - the amount paid and balance owing.

For us to process certain types of extras claims, we need some more information. So, where you have sufficient cover, and you want to make a claim for travel/accommodation, psychology, gym/exercise regimes or the HWFL program, you will need to complete a different claim form. You can get this information from any HCF branch or on www.hcf.com.au/forms or by calling **13 13 34**.

Optical Claims:

Please attach the prescription for glasses and contact lenses.

Medicare Gap Claims:

To claim the Medicare gap for in-hospital services, attach the top portion of Medicare Statement of Benefit to this claim form. The claim will be paid when the related hospital claim has been processed.

Direct Credit:

Benefits for goods and/or services you have already paid can be deposited directly to your bank, building society or credit union account so you receive your refund quicker. Complete Section 4 - Direct Credit account details to set up a direct credit facility.

Cheque Payments:

Cheques will be posted to you. If there is no receipt or the account is unpaid, a cheque in favour of the provider of the goods and/or services will be mailed to you at your mailing address. Forward this cheque together with any balance owing on the account, to the provider.



CLAIM FORM

HCF**More for members.**

The Hospitals Contribution Fund of Australia Limited. ABN 68 000 026 746
HEAD OFFICE: 403 George Street, Sydney NSW 2000
Telephone: 13 13 34. Postal Address: GPO Box 4242, Sydney NSW 2001
E-mail: service@hcf.com.au Internet: www.hcf.com.au

1. Your details: (PLEASE WRITE IN CAPITALS)

HCF Membership Number Title Given Names

Surname Postcode

Phone home Work Mobile

2. Patient and service details: (PLEASE WRITE IN CAPITALS)

Your extras claim details (e.g. dental, optical, physiotherapy)

Name of patient	Date of birth	Treatment type (eg. physiotherapy)	Name of provider (eg. Dr K Brown)	Has account been paid
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes

Your hospital claim details (This section is for medical services received in hospital (and/or outside hospital for Overseas Visitors policy holders))

Name of patient	Date of birth	Inpatient Service	Date of admission	Date of discharge	Hospital Name	Has account been paid
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes

Unless you have requested direct credit, we will pay you by cheque. If the accounts are unpaid, we will make payments directly to the provider.

3. Accident details:

Is any part of this claim related to an accident or incident that may give rise to any form of compensation, damages or payment such as: motor vehicle accident, work related injury, personal injury, sports injury or other?

Yes If 'yes', provide the date of the incident: / / and attach brief details on a separate sheet.

4. Change of details: (Did you know that you can change your details online?)

a. Residential details Yes

Unit/Number Street Suburb/Town Postcode

b. Postal details Yes

Unit/Number Street Suburb/Town Postcode

c. Direct credit account details Yes **Complete this section if your account details have changed or you are setting up a direct credit facility for the first time.**

Name of financial institution Account name

Bank number (BSB) - Account number

Member Declaration

I declare all information provided by me in support of this claim to be true and correct and that all persons covered by this policy whose privacy rights may be affected have been made aware of the HCF Privacy Policy. All goods and/or services were received by the patient and administered by the provider shown. No ancillary benefits are being claimed from HCF that have been, or will be, claimed from Medicare Australia. The patient was not aware of any symptom related to the condition for which benefits are claimed, before joining HCF or transferring to current level of cover. I acknowledge that HCF may need to disclose details of this claim to third parties to establish the correct benefit entitlement and I authorise, and have the consent of the patient, where necessary, to authorise HCF to contact the provider and to access any information needed to verify this claim. I acknowledge that HCF otherwise deals with personal information of patients in accordance with its privacy policy. I confirm I was a financial member of HCF when these goods and/or services were provided and I am authorised to submit this claim as the contributor or contributor's nominated partner on the policy.

Signature of Member or Authorised Partner Listed on Policy

Date

X

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