HCF LINKING PROVIDERS FORM

In order to link providers, we require the signed consent of each provider who is allowing their billing and payment to be handled by another provider (known as the Primary Provider).

For any providers who want to enable benefits to be paid to a Primary Provider, you must acknowledge that you are agreeing to allow the Primary Provider to bill and receive payments for services you provide at the locations listed below, and that HCF will pay the benefits associated with the services being provided at these locations directly to the Primary Provider's nominated bank account.

NOTE – the completion of this form is to enable the billing and payment of benefits to a nominated Primary Provider's bank account only. This does not substitute for entering in an arrangement to participate in HCF's Medicover No or Known Gap scheme. If you do not have a current Medicover No or Known Gap arrangement in place for any of the provider number locations listed on this form MBS benefits only will be paid for your services.

HCF will no longer accept hand written forms and all fields will need to be clearly typed and readable.

1. PROVIDER DETAILS (ASSISTANT OR OTHER)

Provider name

Email address

I give my authority to link the following provider number/s so that the below Primary Provider can bill and receive payments on my behalf.

ASSISTANT / LOCUM PROVIDER NAME	PROVIDER NUMBER	PRIMARY PROVIDER NAME	PRIMARY PROVIDER NUMBER

2. PROVIDER'S DECLARATION

I certify that the above details are correct and acknowledge that my details will only be updated from the date of receipt of this form by HCF.

I acknowledge and agree that I am agreeing to forfeit the ability to bill in my own right for services when linked to the Primary Provider for the provider number locations listed above and that I am assigning the payment of benefits associated with my services at these locations to the Primary Provider.

HCF will no longer accept hand written forms and all fields will need to be clearly typed and readable.

Provider's signature

Date / /

Primary Provider's signature

Date / /

Send your fully completed form to HCF

MAIL TO
HCF Medicover Registration
GPO BOX 4242 Sydney NSW 2001

EMAIL US
HospitalMedicalRegistrations@hcf.com.au

Hospitals Contribution Fund of Australia Limited
ABN 68 000 026 746
403 George Street, Sydney, NSW 2000
GPO Box 4242, Sydney NSW 2001
T 13 13 34

FOR OFFICE USE ONLY

Date of registration

Entered by (User ID)

Date of confirmation letter issued

Reference no. used