

CLAIM FORM



CLAIM FORM CHECKLIST

- I have provided my membership number.
- I have signed the declaration.
- I have attached relevant original itemised receipts and accounts.
- If I am claiming for optical, I have attached the prescription for the glasses and/or contact lenses.
- If I am claiming for an artificial aid or appliance, I have attached a letter from my health care practitioner in support of my claim. (Please call **13 13 34** for details of what to supply to claim for a prescribed aid or appliance)
- If I am claiming for hospital services where I have already claimed from Medicare, I have attached my Medicare statement.
- If I am claiming benefits under School Accident Benefit, I have attached the school incident report in support of my claim.

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 Healthy Weight for Life program, you will need to complete a different claim form. You can get this information from any HCF branch, at hcf.com.au or by calling **13 13 34**.

WHAT YOU NEED TO KNOW WHEN CLAIMING

Accounts and receipts must be original and include the following:

- Service provider's/supplier's full details on official stationery
- Full name and address of the recipient of the services
- Item number(s) and/or description(s) of the services
- Cost of each service
- Date of each service
- Amount paid and balance owing.

Claims must be made within two years of the date of service. If your claim has not been paid, a benefit cheque will be paid to the provider. If you are claiming for pharmacy or Health Dollars, benefits will only be payable where the services have been fully paid by the member.

If your cover includes Health Dollars, these can only be claimed against a hospital excess or items/services that would normally attract a benefit under an extras cover. A front end deductible of \$50 applies to Health Dollars each year but no amount will be deducted for hospital excess claims. Your Health Dollars balance is renewed each year on your Health Dollars renewal date and unused Health Dollars do not accrue to the following year.

HCF reserves its right to recover benefits paid by the fund where the cost of treatment is compensated for and/or reimbursed by a third party. This includes awards of damages, workers compensation and other insurance payments.

DID YOU KNOW YOU CAN CLAIM FOR EXTRAS VIA HCF'S MOBILE APP?



Download the HCF app to your personal device to submit a claim with a photo of your receipt. The app is available for both Apple and Android, see hcf.com.au/mobile-apps

CLAIM PAYMENTS

If you've already paid for the item(s) you're claiming and you have your receipt, benefits will be deposited in the Policyholder's nominated account so you receive your refund quicker. If you haven't nominated an account then the Policyholder will receive a cheque.

If the account is unpaid, a cheque addressed to the provider will be posted to your mailing address in order for you to forward to the provider together with any balance owing on the account.

Ask your provider if they participate in on-the-spot claiming and have your claims paid instantly!

HOW TO CLAIM USING THIS FORM

By mail

- Enclose this fully completed Claim Form plus original itemised accounts and/or receipts relating to the services being claimed.
- Send to: HCF, GPO Box 4242, Sydney NSW 2001

In person at any HCF branch

Please remember your membership card and the original itemised accounts and/or receipts relating to the services being claimed.

For HCF branch locations and operating hours visit hcf.com.au/branches

At Medicare

Leave your HCF claim form and accounts/receipts at any Medicare office.

If you have any questions about your benefits or how to claim, please phone Member Services on 13 13 34.

HCF Membership No.

1 YOUR PERSONAL DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title First name Surname

Postcode Date of birth (DD MM YYYY) Phone - home Mobile

Email address

2 PATIENT AND SERVICE DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Attach a separate sheet to identify additional people covered by the policy if there is insufficient space on this form.

Date of service	First name of the person(s) who received the service	Date of birth	Who provided the service?	Is this account paid in full?	Were any of the services received when in hospital?	Claim health dollars?
/ /		/ /		Yes <input type="checkbox"/>		Yes <input type="checkbox"/> (Eligible products only. See overleaf.)
/ /		/ /		Yes <input type="checkbox"/>		
/ /		/ /		Yes <input type="checkbox"/>		
/ /		/ /		Yes <input type="checkbox"/>		

We will pay you by cheque unless we have your direct credit details. If an account is unpaid, you will receive a cheque in the provider's name.
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 incident, personal injury, sports injury or other?

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

3 CHANGE OF DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Did you know you can change your details online? Login to the member section of our website hcf.com.au/members

Yes a. Residential address:

Suburb State Postcode

Yes b. Postal address:

Suburb State Postcode

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

Account holder name BSB No. Account No.

4 DECLARATION (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

To be completed by the Policyholder or the Partner listed on the policy. A dependant aged 18 years or over who holds an HCF membership card may also sign if this claim relates to them only.

I declare all information provided in support of this claim is true and complete and that all persons covered by the policy whose personal (including sensitive) information is being disclosed to HCF have been made aware of the HCF Privacy Policy. I understand that extras benefits cannot be claimed from HCF that have been, or will be, claimed from Medicare (unless permitted by law). I declare that the patient was not aware of any symptom related to the condition for which benefits are claimed, before joining HCF or transferring to the current level of cover.

I acknowledge that HCF deals with personal information of all members in accordance with its privacy policy. I authorise, and have the consent of the patient, where necessary, to authorise HCF to contact the provider(s) and to access any information including health information needed to verify this claim.

How HCF collects, uses, discloses (which may include obligations to overseas recipients in compliance with its privacy obligations) and keeps and secures personal information including how to opt out from direct marketing, how to request access to and correction of your personal information or how to complain about a privacy breach and how this is handled by HCF is explained in the HCF privacy policy. For a copy of this policy, call our member services team on **13 13 34** or go to hcf.com.au.

Policyholder/Partner/Dependant's name (please circle) Policyholder/Partner/Dependant's signature (please circle) Date (DD MM YYYY)

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