MORE FOR YOU PROGRAM APPLICATION

Apply to be an HCF *More for You program* provider.

Return your completed form

Fax **02 8297 8306**
Email **provider_networks@hcf.com.au**
Mail **Provider Relations**
GPO Box 4242,
Sydney NSW 2001

Medicare provider No.

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

Title

First name

Surname

2 BUSINESS, PRACTICE AND CONTACT DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Business name (if different from section 1)

ABN or ACN

Business name (if different from section 1)

ABN or ACN

Lot number

Suite/unit number

Shop number

Building and floor number/property name (if applicable)

Unit No.

Street No.

Street name

Street type

Suburb

State

Postcode

Phone

Fax

Mobile

Email

@ . .

Website

www.

3 SELECT THE PROGRAM YOU WISH TO PARTICIPATE IN (PLEASE TICK ONE OF THE BOXES BELOW)

- ☐ *More for Backs program* (Chiropractor)
- ☐ *More for Backs program* (Osteopath)
- ☐ *More for Feet program* (Podiatrist)
- ☐ *More for Muscles program* (Physiotherapist)
- ☐ *More for Teeth program* (General Dentist)
- ☐ *More for Eyes program* (Optometrist)
- ☐ *More for Eyes program* (Optical Dispenser)

4 DECLARATION

I understand that HCF provider recognition, including participating in this program, is at HCF's sole discretion. I have read and agree to abide by the Terms and Conditions for HCF Recognised Ancillary Services Providers, the terms and conditions for my selected participating provider network, and the HCF Privacy Policy. I certify that the above details are true and complete.

Signature

X

Date (DD MM YYYY)