PROVIDER REQUEST FOR REVERSAL OF AN ELECTRONIC CLAIM

HCF accepts reversal of an entire transaction only.

Complete and fax to **02 8296 4600**, alternatively you can email **posb_reversal@hcf.com.au** or mail **HCF, GPO Box 4242, Sydney NSW 2001**

Provider No.

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

Provider name

Practice name

Practice address

Unit no. | Street no. | Street name | Street type

Suburb | State | Postcode

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

HCF Membership No. | Patient's given name | Patient's surname

Date of electronic claim (DD MM YYYY)

Electronic claiming terminal

☐ HICAPS ☐ HEALTHPOINT

If this claim is required to be corrected to the correct patient or provider, who should the benefit be paid to?

☐ Provider ☐ Member ☐ N/A

SERVICE DESCRIPTION	ITEM NUMBER	CHARGE	BENEFIT

Reason for this request (please mark 'X')

☐ Cancelled order/service

☐ Incorrect patient — Correct patient name

☐ Incorrect item number

☐ Incorrect provider — Correct provider

☐ Incorrect/incomplete tooth ID or ICD-10-AM code

☐ Other (please include a brief description)

3 DECLARATION

Submitted by:

Print name and position | Email address

Contact number | Signature | Date (DD MM YYYY)

X

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**

The Hospitals Contribution Fund of Australia Limited
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HCF Life Insurance Company Pty Limited
ABN 37 001 831 250 AFSL 236 806

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