CLAIM FORM

CLAIM FORM CHECKLIST

- ☐ I have provided my membership number.
- ☐ I have signed the declaration.
- ☐ I have attached relevant original receipts.
- ☐ 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

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 you're 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 *My Membership* 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 bank account.

If your healthcare provider gives you an unpaid invoice we'll pay the benefits to the Policyholder's nominated bank account and they'll be responsible for making sure your health service provider is paid.

We'll pay your claim into your nominated bank account. If you need to set up direct credit for claim payments for the first time or changed your bank account details make sure you fill in section 3 of this form.

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 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 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 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 paid in full?	Were any of the services received when in hospital?	Claim health dollars?
/ /		/ /		Yes ☐		Yes ☐ *(Eligible products only. See overleaf.)*
/ /		/ /		Yes ☐		
/ /		/ /		Yes ☐		
/ /		/ /		Yes ☐		

We'll pay your claim into your nominated bank account. If you need to set up direct credit for claim payments for the first time or changed your bank account details make sure you fill in section 3 of this form.

If your healthcare provider gives you an unpaid invoice we'll pay the benefits into the Policyholder's nominated bank account and they'll be responsible for making sure your health service provider is paid.

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 DIRECT CREDIT PAYMENT DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Only complete this section if your account details have changed or you are setting up direct credit for the first time. Leave blank if your payment details haven't changed.

Account holder name | BSB No. | Account No.

Do you need to update any other details? You can make updates online by logging in to online member services at hcf.com.au/members

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, during the 6 months before joining HCF or transferring to the current level of cover, or if they were aware of any such symptom they have served any applicable waiting periods.

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)

X | X

The Hospitals Contribution Fund of Australia Limited.
ABN 68 000 026 746 AFSL 241 414.

HCF Life Insurance Company Pty Limited.
ABN 37 001 831 250 AFSL 236 806

HCF House 403 George Street, Sydney, NSW 2000
Postal Address: GPO Box 4242, Sydney NSW 2001

hcf.com.au

HCF Claim form 1220