HCF LINKING PROVIDERS

In order to link providers, we require the signed consent of each assist surgeon. For any providers who want to enable benefits to be paid to the primary, the assist must acknowledge that they forfeit the ability to bill in their own right when working with the primary providers and that HCF will pay the benefits associated with the services they are providing in association with the primary provider.

Complete and send form to:
Email:
Medicoverenquiry@hcf.com.au
Or
Mail: HCF Medicover Registration
GPO Box 4242
SYDNEY NSW 2001

1. Provider Details (Assist)

Provider Name

Email address

I give my authority to link the following provider number/s so that the below Primary surgeon/s can claim on my behalf.

Assisting Provider Name	Assisting Provider Number	Primary Surgeon Name	Primary Surgeon Provider Number

3. 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 forfeiting my ability to claim in my own right when linked to the primary surgeon 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 surgeon.

Assisting Provider's Signature:

Date / /

Primary Provider's Signature:

Date / /

Office use only
Date of registration_____ Entered by (User ID)_____
Date Confirmation Letter issued_____ Reference No.used_____

HCF Provider Linkage Form V102017