

# HCF MEDICOVER CHANGE OF EXISTING DETAILS FORM

This form is for providers who are already HCF Medcover registered providers. To *Register for Medcover* for the first time or *Change Your Nomination* for Medcover please visit:  
[www.hcf.com.au/HCFMedicalProviderPortal](http://www.hcf.com.au/HCFMedicalProviderPortal)

## How to use this form:

- To change the postal address, email address or contact number for your provider number please complete sections 1 and 3
- To change the Bank Account Details for your HCF Medcover registered provider numbers, please fill in sections 1, 2 and 3.
- Details will only be changed for the provider numbers listed on this form.

## 1. PROVIDER DETAILS

Provider name

Provider numbers

Postal address (for correspondence)\*

Practice phone no\*

Practice email address\*

Public hospital providers please confirm you are a visiting medical officer in private practice

 Yes, I confirm I am a visiting medical officer in a private practice

Preferred HCF participating hospital for treatment

Area of speciality

Contact person's name

Contact person's phone no.

Contact person's email address

## 2. ACCOUNT DETAILS

Please fill in the banking details below.

If you have providers that are attached to a different bank account, please register these on another registration form.

Financial institution name

Financial institution address

Account name

Account BSB & number

BSB:

Number:

### 3. PROVIDER'S DECLARATION

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Please update my details for my HCF Medcover Registration. I have read and agree to the HCF Medcover Terms and Conditions which include the HCF Privacy Policy.

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 authorise payment of benefits to be credited to my account by electronic funds transfer. I acknowledge that HCF will not accept any liability if banking details provided by me are incorrect. HCF requires at least **14 day's notice** if banking details change or we will not be responsible for payments going in to the incorrect account.

**Provider's signature**

**Date**

 

The HCF Medcover Terms and Conditions can be found on the HCF Provider Portal, HCF's Privacy Policy may be found at:

[www.hcf.com.au/privacy-policy/](http://www.hcf.com.au/privacy-policy/)

**Send your fully completed form to HCF:**



MAIL TO

**HCF Medcover Registration  
GPO BOX 4242 Sydney NSW 2001**



EMAIL US

**HospitalMedicalRegistrations@hcf.com.au**

**Hospitals Contribution Fund of Australia Limited**

ABN 68 000 026 746

403 George Street, Sydney, NSW 2000

GPO Box 4242, Sydney NSW 2001

T 1800 670 302

**FOR OFFICE USE ONLY**

Date of registration

Entered by (User ID)

Date of confirmation letter issued

Reference no. used