From 30 March 2020 until 31 December 2022 in response to the COVID-19 physical distancing measures, we are relaxing our requirement for in-person treatment so members can receive benefits for telehealth services whose codes are listed below. These services include birthing classes, exercise physiology, dietetics, physiotherapy, podiatry, occupational therapy, psychology and speech pathology. Please complete and give this form to your HCF patients to submit to us along with your invoice.

1. **MEMBER DETAILS** (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)
   - **First name**
   - **Surname**
   - **Date of birth (DD MM YYYY)**

2. **PROVIDER DETAILS** (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)
   - **Name**
   - **Provider number**
   - **Phone**
   - **Mobile**

3. **TYPE OF TELEHEALTH CLAIM**
   - **Birthing Classes**
   - **Dietetics**
     - 301 (Individual initial assessment by teleconsultation)
     - 302 (Individual subsequent treatment by teleconsultation)
   - **Exercise Physiology**
     - 710 (Individual initial assessment by teleconsultation)
     - 712 (Individual subsequent treatment by teleconsultation)
   - **Lactation Consultation**
   - **Occupational Therapy**
     - 601 (Individual initial assessment by teleconsultation)
     - 602 (Individual subsequent treatment by teleconsultation)
   - **Physiotherapy**
     - 811 (Individual initial assessment by teleconsultation)
     - 812 (Individual subsequent treatment by teleconsultation)
   - **Podiatry**
     - 901 (Individual initial assessment by teleconsultation)
     - 902 (Individual subsequent treatment by teleconsultation)
   - **Psychology after Medicare GP Mental Health Plan used up**
     - 801 (Individual subsequent treatment by teleconsultation)
     - I certify that the patient above has had a Medicare entitlement to psychology for this year and has exhausted his or her psychology benefits for the calendar year
   - **Speech Pathology**
     - 501 (individual initial assessment by teleconsultation)
     - 502 (individual subsequent treatment by teleconsultation)

4. **DESCRIPTION OF CONDITION BEING TREATED (OR ICD-10 CODE)** (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)
   - **Date of service (DD MM YYYY)**
DECLARATION

I declare that:

• all the information on this form is true and correct;
• I provided the services detailed above using the following secure, industry approved telehealth platform;
• these telehealth services have not been claimed through Medicare or any other third party;
• I understand and have upheld my privacy obligations;
• I have read, and confirm that I am compliant with, my Association’s telehealth guidelines;
• I understand that the HCF Fund Rules and HCF Terms and Conditions for Recognised Providers of General Treatment still apply to all claims, including invoicing and recognition requirements; and
• I understand that these telehealth benefits are temporary and only apply to eligible services delivered from 30 March 2020 until 31 December 2022.

Signature

Date (DD MM YYYY)

X

• if you choose to sign by use of digital signatures, I confirm that I consented to the use of digital signatures and it is my signature affixed to this form.