

3. ACCOUNT DETAILS

Please fill in the banking details below.

Financial institution name

Financial institution address

Account name

Account BSB & number

BSB:

Number:

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

4. MEDICAL PROVIDER DECLARATION

Please register me as a HCF Medcover Provider for the provider numbers detailed above. I have read and agree to the HCF Medcover Terms and Conditions which include the HCF Privacy Policy. I understand that I will receive HCF benefits in accordance with the Medcover arrangement I have nominated ie. No Gap or Known Gap and confirm that I am not a salaried doctor at a public hospital, pathologist or radiologist.

I declare that I am a private practice provider as defined in the terms and conditions.

I certify that the above details I have provided are correct and acknowledge that my Medcover Registration will only be effective from the date this completed form is received by HCF.

I authorise payment of benefits to be credited to my nominated account/s by electronic funds transfer.

I acknowledge that HCF will not accept any liability if banking details provided by me are incorrect. HCF requires 14 days' notice if banking details change.

I acknowledge that HCF will send me confirmation of receipt of this application within 30 days. If I have not heard back from HCF I will follow up the status of my application or accept that my application has not been received.

Medical provider's signature

Date

This declaration MUST be signed by the Medical Provider applying for registration.

Registrations are commenced from the date they are received by HCF and will not be backdated.

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/about-us/about-HCF/governance-and-structure/policies/privacy-policy

For assistance in completing this registration form or to enquire about HCF's medical arrangements for salaried doctors at public hospitals, radiologists or pathologists please contact **1800 670 302**

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

HCF Medcover Registration V042020