

Claim form checklist

- I have provided my membership number.
- I have signed the declaration.
- I have attached relevant original itemised receipts and accounts.
- If I am claiming for Orthodontics, I have attached an itemised quote/treatment plan or completion letter provided by my dentist/orthodontist.
- 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 the top section of my Medicare statement.

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 www.hcf.com.au or by calling **13 13 34**.

What you need to know when claiming

Accounts and receipts must be original and include the following:

- The service provider's/supplier's full details on official stationery.
- The full name and address of the recipient of the services.
- The item number(s) and or description(s) of the services.
- The cost of each service.
- The date of each service.
- The amount paid and balance owing.

Claims must be made within two years of the date of service. If your claim has not been paid, a benefit cheque will be paid to the provider. If you are claiming for Pharmacy or Health Dollars, benefits will only be payable where the services have been fully paid by the member.

If your product 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. This additional benefit is limited to the difference between the receipted cost of the extras item and the benefit that has previously been paid.

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.

Claim payments

Benefits for goods and/or services for which you have already paid will be deposited in your nominated account so you receive your refund quicker. If there is no receipt or the account is unpaid, a cheque in favour of the provider will be posted to your mailing address in order for you to forward to the provider together with any balance owing on the account.

Ask your provider if they participate in on-the-spot claiming and have your claims paid instantly!

How to claim

By mail

- Enclose a fully completed Claim Form plus original itemised accounts and/or 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 itemised accounts and/or receipts relating to the services being claimed.

For HCF branch locations and operating hours visit www.hcf.com.au

At Medicare

We have a two-way agency agreement with Medicare whereby you can leave your HCF claim form and accounts/receipts at any Medicare office to be forwarded to us.

If you have any questions about your benefits or how to claim, please phone Member Services on 13 13 34.

HCF Claim form



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

Head Office: 403 George Street, Sydney NSW 2000
Telephone: 13 13 34. Postal Address: GPO Box 4242, Sydney NSW 2001
E-mail: service@hcf.com.au Internet: www.hcf.com.au

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 no Mobile

Email @

2 Patient and service details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Your claim details (e.g. dental, optical, physiotherapy, medical and ambulance) including Overseas Visitors Health Cover

| Date of service | First name of the person(s) who received the service | Date of birth | Who provided the service? | Is this account paid in full? | Claim Health Dollars |
|-----------------|--|---------------|---------------------------|-------------------------------|------------------------------|
| / / | | / / | | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| / / | | / / | | <input type="checkbox"/> Yes | |
| / / | | / / | | <input type="checkbox"/> Yes | |
| / / | | / / | | <input type="checkbox"/> Yes | |

We will pay you by cheque unless we have your direct credit details. If an account is unpaid, you will receive a cheque in the provider's name.
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 details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Did you know you can change your details online?

Yes a. Residential address: Unit No. Street No. Street name

Suburb State Postcode

Yes b. Postal address: Unit No. Street No. Street name

Suburb State Postcode

Yes c. Direct credit account details:
Complete this section if your account details have changed or you are setting up a direct credit facility for the first time.

Account holder name BSB No. Account No.

4 Declaration

To be completed by the Policyholder or Partner listed on policy

I declare all information provided in support of this claim is true and correct and that all persons covered by this 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, before joining HCF or transferring to the current level of cover.

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.

Signature must be of the Policy holder or Partner listed on policy

Date (DD MM YYYY)

PRIVACY How HCF collects, uses, keeps and secures personal information is described in the HCF Privacy Policy. For a copy of this policy, visit a branch, call 13 13 34 or log onto hcf.com.au. For more information, please call HCF Member Information on 13 13 34