

1. Your de	etails: (PLEASE WRITE IN CAP	ITALS)			
Membership Number First Names			Date of birth		
Surname			Postcode Contact number		
2. Patient	and service details: (PLEASE W	RITE IN CA	APITALS)		
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
				Yes	
				Yes	Yes
				Yes	103
				Yes	
Unless you have the provider's i	. ,	tails, we will 1	pay you by cheque. If an account is unpaid, v	we will send you a cl	neque in
Is any part of the			ay give rise to any form of compensation, da ts injury or other?	mages or payment s	uch as:
Yes If 'y	yes', provide the date of the incident:		and attach brief details on	a separate sheet.	
3 Change	of details: (Did you know that you	can change v	our details online?)		
a. Residential		g- /	Street		
a. Residentiai	details les Only Number		Street		
Suburb/Town			Postcode		
			_		
b. Postal details Yes Unit/Number		Street			
Suburb/Town			Postcode		
c. Direct credi			tion if your account details have changed or the first time.	you are setting up	a direct
Account name		·		ount number	
4. Declara	ition				
affected have bee from Medicare A claimed, before j I acknowledge th	en made aware of the HCF Privacy Policy. Australia (unless permitted by law). I declar oining HCF or transferring to the current hat HCF deals with personal information of	I understand to the that the pati- toler level of cover. of all members	correct and that all persons covered by this policy hat extras benefits cannot be claimed from HCF tent was not aware of any symptom related to the continuous in accordance with its privacy policy. I authorise, o access any information needed to verify this claim	that have been, or will condition for which be and have the consent	be, claimed enefits are
Signature must be of the Policy holder or Partner listed on Policy  X SIGN HERE			Date		

# Claim form checklist I have provided my membership number. I have signed the declaration. I have attached relevant receipts and accounts. If I am claiming for Orthodontics, I have attached a quote/ treatment 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 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 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, Quit Smoking 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 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 account and/or receipts.

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 benefit entitlements please phone Member Services on 13 13 34.



# 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