HCF MEDICOVER APPLICATION FORM FOR REGISTERING PROVIDER LOCATIONS

HCF Medicover is not available to Pathologists, Radiologists or Doctors employed fully or partially by a publicly funded facility.

To change Bank Account details, Postal Address and contact information or Change Your Nomination for existing Medicover registrations please visit: **www.hcf.com.au/HCFMedicalProviderPortal**

1. PROVIDER DETAILS

*Details must be completed for your registration form to be processed.

Provider name*

Area of speciality*

Practice phone no*

( )

Email address*

contact@billingplus.com

Postal address (for correspondence)*

c/o 27 EROWAL STREET, BEAUMARIS VIC 3193

Contact person name*

Tom Brockhurst

Phone number

( ) 1300923955

Email*

contact@billingplus.com

2. PROVIDER NUMBERS

If any of your provider numbers are for public hospitals where you are not a VMO with right of private practice, you are not able to register them with HCF under Medicover.

Only use one provider number in each line. Only one nomination can be selected per provider number.

If you have more than six provider numbers please attach a list including all provider details for each additional number.

PROVIDER NUMBERS	FACILITY/ HOSPITAL NAME OR LOCATION ASSOCIATED WITH PROVIDER NUMBER	MUST TICK ONLY ONE OPTION PER PROVIDER NUMBER		CLAIM SUBMISSION METHOD	
		NO GAP RECOGNISED PROVIDER	KNOWN GAP RECOGNISED PROVIDER	ECLIPSE	MANUAL (POST)
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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 Medicover Provider for the provider numbers detailed above. I have read and agree to the HCF Medicover Terms and Conditions which include the HCF Privacy Policy. I understand that I will receive HCF benefits in accordance with the Medicover 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 certify that the above details I have provided are correct and acknowledge that my Medicover 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 day's notice if banking details change.

I acknowledge that HCF will send me confirmation of receipt of this application within 14 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 Medicover 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/**

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 Medicover Registration
GPO BOX 4242 Sydney NSW 2001

EMAIL US
medicoverenquiry@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