

## Important Information

To ensure your claim is attended to promptly, please note:

- Membership:** Membership contributions must be up to date or your claim may not be paid.
- Claims:**
- Ensure all requested information is provided with your claim. A checklist is provided on the front page of this Claim form.
  - Remember to lodge your claims within two (2) years of the goods and/or services being provided otherwise your claim may not be paid.
  - A claim may not be made for any goods and/or services until they are actually provided.
  - Goods and/or services received while overseas are not claimable from HCF.
  - Please ensure you have attached to this claim form the original account(s) and/or receipt(s) from the provider. All accounts and/or receipts should show the name and address of the provider, type of goods and/or service, date of receipt of the goods and/or service, patient's name, the cost of the goods and/or service. HCF must keep your original account(s) and receipt(s) for audit purposes.
- Optical Claims:** Attach the prescription for glasses and contact lenses.
- Medicare Gap Claims:** In order to claim the Medicare gap for in-hospital services, you will need to attach the top portion of Medicare Statement of Benefit to this claim form. This claim can only be paid once the related hospital claim has been processed.
- Direct Credit:** Claims where the goods and/or services have already been paid by you can be paid directly to your bank, building society or credit union account. This means you will receive your refund sooner and avoid any delay in the clearance of the cheque by the financial institutions. We will send a statement to you confirming the payment details.
- Account details can usually be obtained from your account statement. If you are unsure please check with your financial institution.
- Cheque Payments:** Cheques will be posted to you at your mailing address. If the account is unpaid, a cheque in favour of the nominated provider of the goods and/or service will be mailed to you. Forward this cheque together with the balance owing on the account, if any, to the provider.
- If you have any questions or you are in doubt about any aspect of your claim, our Customer Service Officers at any of our branches will be pleased to help. Alternatively, you may phone the HCF Member Information Line from anywhere in Australia for the cost of a local call.

## We're different.

The Hospitals Contribution Fund of Australia Limited. ABN 68 000 026 746.  
HCF Life Insurance Company Pty Limited. ABN 37 001 831 250.  
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Postal Address: GPO Box 4242, Sydney 2001. Telephone: 13 13 34.  
E-mail: [service@hcf.com.au](mailto:service@hcf.com.au) Internet: [www.hcf.com.au](http://www.hcf.com.au)

# PRIORITY MAIL CLAIM

## To make a claim:

- Read the **Important Information** on the back page of this claim form
- Write your Membership Number at the top of the claim form  
(*the Membership Number is shown on your HCF Membership Card*)
- Membership details **SECTION 1**
- Payment method **SECTION 2**  
(*only applicable if account has been paid by you*)
- Claim details **SECTION 3 AND 4**
- Accident details **SECTION 5**
- Sign and date the Declaration and Authority Section **SECTION 6**
- Attach all **original** accounts and/or receipts to this claim form
- Mail the completed claim form to your nearest HCF branch or to:  
**The Hospitals Contribution Fund of Australia Limited**  
**GPO Box 4242 Sydney NSW 2001**

# HCF PRIORITY MAIL CLAIM

HCF Membership No. \_\_\_\_\_

## MEMBERSHIP DETAILS SECTION 1

Title \_\_\_\_\_ Given Names \_\_\_\_\_ Surname \_\_\_\_\_

Current Mailing Address \_\_\_\_\_

Postcode \_\_\_\_\_

Phone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Email Address \_\_\_\_\_

## PAYMENT BY DIRECT CREDIT SECTION 2

If the account is UNPAID, a cheque in favour of the provider/doctor will be mailed to you. If the account has already been PAID, we will pay your benefits by DIRECT CREDIT to your already nominated bank/building society/credit union account. If you have not previously provided us with your nominated account details, or if they have changed since your last claim, please provide the following details:

Financial Institution Name \_\_\_\_\_ Bank No. (BSB) \_\_\_\_\_

Account Name \_\_\_\_\_ Account Number \_\_\_\_\_

OR if you prefer, we will send you a cheque, simply tick this box

## CLAIM DETAILS SECTION 3

Were any of the services performed while the patient was admitted to a hospital or approved day hospital? Yes  No  (if ticked NO, go to Section 4)

If 'yes', please advise: Period in hospital / / to / /

Name and address of hospital \_\_\_\_\_

(required for claims not

Medicare No. \_\_\_\_\_ Medicare Patient ID No. \_\_\_\_\_ lodged with Medicare)

**Informed Financial Consent.** Was the patient/member advised by their doctor, either in writing or verbally, of the likely charges and out of pocket expenses that MAY incur as a result of the treatment being provided? Yes  No

**Disclosure of Financial Interest.** Did the doctor disclose to the patient/member *whether or not* they had any financial interest in any products (i.e. prosthesis, pharmaceuticals, etc.) or services (i.e. pathology, scans, etc.) that were provided as part of the treatment? Yes  No

**Consent/Disclosure of Interest Provided PRIOR to Treatment.** If the response to either or both of the above questions was YES, was the informed financial consent and/or disclosure of the doctor's financial interests provided PRIOR to the commencement of the treatment? Yes  No

## SECTION 4 To be completed for all claims.

Date of Service	Patient Name & Initials	Sex	Date of Birth	Name of Provider/Doctor	Type of Service	Account Paid	
						Yes	No
<i>*Example</i>							
<i>*3.3.00</i>	<i>Rachel A</i>	<i>F</i>	<i>8.6.88</i>	<i>Dr D.U. Floss</i>	<i>Dental</i>	<input checked="" type="checkbox"/>	

## ACCIDENT DETAILS SECTION 5

Is this claim the result of an accident? Yes  No  If 'yes', the date of the accident was / /

Is the patient entitled to any form of compensation, damages or payment as a result of the accident? Yes  No

If 'yes', please provide brief details \_\_\_\_\_

## DECLARATION AND AUTHORITY SECTION 6

I declare all information stated in this claim form and any supporting documentation to be true and correct. All goods and/or services were received by the patient and administered by the provider shown. No ancillary benefits are being claimed from HCF that have been, or will be, claimed from Medicare. The patient was not aware of any symptom related to the condition for which benefits are claimed before joining HCF or transferring to current level of cover. I acknowledge that HCF may need to disclose details of this claim to third parties to establish the correct benefit entitlement and I authorise HCF to contact the provider and to access any information needed to verify and process this claim. I acknowledge that HCF otherwise deals with personal information of patients in accordance with the terms of its privacy policy, which is available on the HCF website, or by request from HCF branches. I confirm I was a financial member of HCF when these goods and/or services were provided and I am authorised to sign the claim form as the contributor or contributor's nominated partner on the policy.

Signature of Member \_\_\_\_\_ Date / / \_\_\_\_\_