

# CLAIM FORM



## CLAIM FORM CHECKLIST

- I've provided my membership number.
- I've signed the declaration.
- I've attached relevant original receipts.
- If I'm claiming for optical, I've attached the prescription for the glasses and/or contact lenses.
- If I'm claiming for an artificial aid or appliance, I've attached a letter from my healthcare 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'm claiming for hospital services where I've already claimed from Medicare, I've attached my Medicare statement.
- If I'm claiming benefits under School Accident Benefit, I've attached the school incident report in support of my claim.
- If I'm claiming benefits under Accident Benefit, I've attached the treating medical practitioner's report in support of my claim.
- If I'm claiming benefits for car travel to attend a medical specialist consultation under my extras cover, I've attached documents showing evidence of the consultation.

If you have a claim for travel/accommodation where you had a hospital admission, psychology, gym/exercise program or weight management program you'll need to make sure you're covered for these services and submit a different claim form. You can find additional forms by visiting [hcf.com.au/forms](http://hcf.com.au/forms), calling **13 13 34** or visiting your nearest branch.

## CLAIMS FOR TRAVEL AND ACCOMMODATION BENEFITS

If you're claiming for travel and accommodation benefits where you travelled by car, complete this claim form.

For other types of travel and accommodation claims, you must include the receipt/s for your travel and accommodation and proof of specialist attendance but won't need to complete a claim form.

Where you're claiming travel and accommodation benefits as part of travelling to hospital for a hospital admission, you'll need to fill out the **Application to Claim Travel and Accommodation for Hospital Admissions** available at [hcf.com.au/forms](http://hcf.com.au/forms), by calling **13 13 34** or visiting your nearest branch.

## WHAT YOU NEED TO KNOW WHEN CLAIMING

Claims must be made within 2 years of the date of service. Make sure you have original receipts and they include the following:

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

We have the right to recover benefits paid 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.

## FAST CLAIMS WITH THE HCF MY MEMBERSHIP APP



You can make an extras claim in minutes with our quick and easy claims experience by downloading the HCF *My Membership* app. The app is available from the App Store or Google Play, see [hcf.com.au/mobile-apps](http://hcf.com.au/mobile-apps)

## CLAIMING WITH HEALTH DOLLARS

If you're claiming for pharmacy or Health Dollars, benefits will only be payable where the services have been fully paid by you.

If your cover includes Health Dollars, these can only be claimed against a hospital excess or items/services that pay a benefit under your extras cover. A front end deductible of \$50 applies to Health Dollars each year but no amount is payable for hospital excess claims. Your Health Dollars balance renews each year on your Health Dollars renewal date and unused Health Dollars don't accrue to the following year.

## CLAIM PAYMENTS

If you've already paid for the item(s) you're claiming and you have your receipt, benefits will be deposited in the Policyholder's nominated bank account.

If your healthcare provider gives you an unpaid invoice we'll pay the benefits to the Policyholder's nominated bank account and they'll be responsible for making sure your healthcare provider is paid.

If you need to set up direct credit for claim payments for the first time or have changed your bank account details make sure you fill in section 3 of this form.

**Ask your provider if they participate in on-the-spot claiming and have your claims paid instantly with your membership card.**

## HOW TO CLAIM USING THIS FORM

### BY MAIL

Send this fully completed claim form plus original receipts relating to the services being claimed to **HCF, GPO Box 4242, Sydney NSW 2001**

### OTHER WAYS TO CLAIM

#### ON THE SPOT

You can use your digital or physical membership card to claim on the spot at selected extras providers. You'll need to pay any difference that's owing.

#### APP AND ONLINE

You can upload your extras or ambulance claim with our My Membership app or log in to online member services at [hcf.com.au/members](http://hcf.com.au/members)

#### IN PERSON AT ANY HCF BRANCH

Bring your membership card and the original receipts relating to the services being claimed to your nearest branch. For locations and opening hours visit [hcf.com.au/branches](http://hcf.com.au/branches)

HCF Membership No.

**1 YOUR PERSONAL DETAILS** (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title	First name	Last name		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Postcode	Date of birth (DD MM YYYY)	Phone	Mobile	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address				
<input type="text"/>				

**2 PATIENT AND SERVICE DETAILS** (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

You can attach a new page and include the patient and service details if there isn't enough space on this form.

Date of service	First name of the person(s) who received the service	Date of birth	Who provided the service?	Is this paid in full?	Were any of the services received when in hospital?	Claim Health Dollars?
/ /		/ /		Yes		Yes (Eligible products only. See cover page.)
/ /		/ /		Yes		

We'll pay your claim into your nominated bank account. If you need to set up direct credit for claim payments for the first time or changed your bank account details make sure you fill in section 3 of this form.

If your healthcare provider gives you an unpaid invoice we'll pay the benefits into the Policyholder's nominated bank account and they'll be responsible for making sure your healthcare provider is paid.

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.

Is any part of this claim related to travel and accommodation benefits?	Return distance between home and hospital	Date travel commenced (DD MM YYYY)	Return date (DD MM YYYY)
Yes <input type="checkbox"/> If 'yes', fill out the travel details	<input type="text"/> km	<input type="text"/>	<input type="text"/>

**3 CHANGE OF DIRECT CREDIT PAYMENT DETAILS** (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Only complete this section if your account details have changed or you're setting up direct credit for the first time. Leave blank if your payment details haven't changed.

Account holder name	BSB No.	Account No.
<input type="text"/>	<input type="text"/>	<input type="text"/>

 Do you need to update any other details? You can make updates online by logging in to online member services at [hcf.com.au/members](http://hcf.com.au/members)
**4 CARER DETAILS** (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

 Was a carer required to support the patient's travel, or provide support before and after hospitalisation? Yes  No 

Carer's name and relationship to claimant (for e.g. family member, friend).

Benefits are only payable for your carer's travel expenses if they were incurred while they travelled with you to and from the hospital.

**5 DECLARATION** (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

**To be completed by the Policyholder or the Partner listed on the policy. A dependant aged 18 years or over who holds an HCF membership card may also sign if this claim relates to them only.**

I declare all information provided in support of this claim is true and complete.

I acknowledge that HCF deals with personal information of all members in accordance with its privacy policy. I consent to HCF using the information in this form to assess my claim for travel and accommodation expenses and I authorise HCF to contact the provider(s) specified on this form and to collect and use any information including health information from the provider needed to verify this claim. I acknowledge that if I do not provide the information required in this form, HCF will not be able to assess my claim or pay benefits.

 How HCF collects, uses, discloses (which may include obligations to overseas recipients in compliance with its privacy obligations) and keeps and secures personal information including how to opt out from direct marketing, how to request access to and correction of your personal information or how to complain about a privacy breach and how this is handled by HCF is explained in the HCF privacy policy. For a copy of this policy, call us on **13 13 34** or go to [hcf.com.au](http://hcf.com.au)

Name of the person making the claim	Signature of the person making the claim	Date (DD MM YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>