OVERSEAS VISITORS HEALTH COVER CLAIM FORM

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 hospital services, I have attached the hospital claim form.

WHAT YOU NEED TO KNOW WHEN CLAIMING

Accounts and receipts must be original and 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.

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

HCF will not pay any benefit should compensation, damages or benefits be payable by a third party. For example, workers compensation.

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

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 account so you receive your refund quicker.

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

HOW TO CLAIM USING THIS FORM

By email

Attach this fully completed claim form plus original itemised accounts and/or receipts relating to the services being claimed and email to **OVHC_service@hcf.com.au**

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 **hcfvisitorhealthcover.com**

Please complete all the relevant sections of the claim form using CAPITAL LETTERS and a black pen. Mark all appropriate boxes with a CROSS (X). **All areas marked with an ASTERISK (*) must be completed.**

HCF Membership No.*

1 YOUR PERSONAL DETAILS*

Title | First name | Surname

Postcode | Date of birth (DD MM YYYY) | Phone - home | Mobile

Email address

2 PATIENT AND SERVICE DETAILS*

Attach a separate sheet to identify additional people covered by the policy if there is insufficient 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 account paid in full?	Were any of the services received when in hospital?
/ /		/ /		Yes ☐	
/ /		/ /		Yes ☐	
/ /		/ /		Yes ☐	
/ /		/ /		Yes ☐	

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 REIMBURSEMENT OF CLAIMS

Complete this section if your account details have changed or you are setting up a credit facility for the first time. Please note we will only pay into an Australian Bank account. If this section is not completed and there are no bank account details on file, please be aware we may not be able to process your claim.

Account holder name | BSB No. | Account No.

4 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 OVHC membership card may also sign if this claim relates to them. An authorised third party may also complete this form on a members behalf but only if a Authority - Nomination by Overseas Visitors Health Cover Policyholder form has been signed and returned to HCF.

I declare all information provided in support of this claim is true and complete and that all persons covered by the policy whose personal (including sensitive) information is being disclosed to HCF have been made aware of the HCF Privacy Policy. 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.

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 our member services team on **13 68 42** or go to **hcfvisitorhealthcover.com**

Policyholder/Partner/Dependant's name (please circle) | Policyholder/Partner/Dependant's signature (please circle) | Date (DD MM YYYY)

X | X