

RT HEALTH AND TRANSPORT HEALTH MEDICOVER REGISTRATION FORM

The rt health and Transport Health Medicover scheme is not available to Pathologists, Radiologists or Staff Specialists employed fully or partially by a public funded facility.

1. PROVIDER DETAILS		*Details must be completed for your registration form to be processed
Provider name*		Area of speciality/field of speciality practice*
Practice phone no*		Email address*
Postal address (for correspondence)*		
Contact person name*	Phone number	Email*
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2. PROVIDER NUMBERS		

NOTES:

1. Only Visiting Medical Officers (VMOs) with rights of private practise may register to participate in the rt health and Transport Health Medicover Scheme.

PROVIDER NUMBERS	R NUMBERS FACILITY/HOSPITAL NAME OR LOCATION ASSOCIATED WITH	PLEASE TICK IF PROVIDER NUMBER RELATES TO A PUBLIC FACILITY		
PROVIDER NUMBER PROVIDER NUMBER	VISITING MEDICAL OFFICER (VMO)	SALARIED		

3. ACCOUNT DETAILS

Financial institution name	Financial institution address	3
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 an rt health and Transport Health Medicover Provider for the provider numbers detailed above. I have read and agree to the rt health and Transport Health Medicover Terms and Conditions which include the HCF Privacy Policy. I understand that I will receive rt health and Transport Health benefits in accordance with the Medicover arrangement and confirm that I am not a salaried doctor at a public hospital, pathologist or radiologist.

I declare that I am a private practice provider as defined in the rt health and Transport Health Medicover terms and conditions.

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, rt health or Transport Health will not accept any liability if banking details provided by me are incorrect. HCF requires 14 days' notice if banking details change.

I acknowledge that HCF will send me confirmation of receipt of this application within 30 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 rt health and Transport Health Medicover Terms and Conditions can be found on the HCF Provider Portal. rt Health and Transport Health's Privacy Policy may be found at www.hcf.com.au/about-us/about-HCF/governance-and-structure/policies/privacy-policy.

For assistance in completing this registration form or to enquire about rt health and Transport Health's medical arrangements for salaried doctors at public hospitals, radiologists or pathologists please contact **medicover@hcf.com.au**.

Send your fully completed form to HCF



rt health and Transport Health Medicover Registration GPO BOX 4242 Sydney NSW 2001



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