RT HEALTH
HEALTH MEDICOVER
REGISTRATION FORM

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

RT Health will no longer accept handwritten forms and all fields will need to be clearly typed and readable.

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*

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

Please fill in the banking details below.

3. ACCOUNT DETAILS

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 an RT Health Medicover Provider for the provider numbers detailed above. I have read and agree to the RT Health Medicover Terms & Conditions which include the HCF Privacy Policy. I understand that I will receive RT 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 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 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 Medicover Terms and Conditions can be found on the HCF Provider Portal. RT 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'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

MAIL TO
RT Health
Medicover Registration
GPO BOX 4242 Sydney NSW 2001

EMAIL US
Medicover@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