RT HEALTH MEDICOVER CHANGE OF EXISTING DETAILS FORM

This form is for providers who are already registered as RT Health Medicover providers.

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

1. PROVIDER DETAILS

Provider name

Provider numbers

Postal address (for correspondence) *

Contact person's phone no.

( )

Contact person's email address

2. ACCOUNT DETAILS

Please fill in the banking details below.

If you have providers that are attached to a different bank account, please register these on another registration form.

Financial institution name

Financial institution address

Account name

Account BSB & number

BSB: Number:

3. PROVIDER'S DECLARATION

Please update my details for my RT Health Medicover Registration. I have read and agree to the RT Health Terms & Conditions and Privacy Policy

I certify that the above details are correct and acknowledge that my details will only be updated from the date of receipt of this form by HCF.

I authorise payment of benefits to be credited to my account 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 at least **14 days' notice** if banking details change or HCF, RT Health will not be responsible for payments going into the incorrect account.

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Provider's signature

Date

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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.

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