

Online Patient Eligibility Check (ECF Web) Hospital Registration Form

Instruction to referring fund:

Please email completed form to: eclipse_help@civica.com.au

-----The following section MUST be filled in by the referring fund.-----

Referred by:

Health Fund:

Signature (Health Fund
Representative's):

Date:

----The following section MUST be filled in by the Hospital Institution.----

Hospital/Institution Name:

Contact Address:

Contact Person:

Contact Phone:

Contact Email:

Facility Number:

Facility Name:

Hospital Host IP Address:

We have read and understood the Civica ECF Web Eclipse Patient Eligibility Guide.

Name of Applicant (Provider
Representative's):

Position Title:

Signature (Provider Representative's):

Date: