

# Claim Form

Please return or email this form to:

24 Upper Ground, London, SE1 9PD Tel: 020 7202 1381 Email: claims@hsf.eu.com



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## To be Completed by the Policyholder (All claims must be made within 6 months.)

_							HSF USE
Forename							
Surname							
Address				Postcode			
Policy No				<b>Telephone Number</b>			
Employer				Email Address			
In order to receive settle savings account) held in			se provide your			dit a current a	account (not a
Account No:				Sort C	ode:	, - , - ,	
Account Name:							
Patient Forename							
Patient Surname							
Date of Birth			Policyholder	Spouse	/Dartner	Child u	nder 18
Date of Birtin			Folicyfloidei	Spouse	raitiei		ease tick/select one
TO BE COMPLETED B	Y THE PAT	TIENT OR GUA	RDIAN OF CHILI	O UNDER THE AGE O	F 18:		
I, the patient/guardian of t	the named	above, was an i	n-patient at the Ho	ospital/Hospice mention	ned below.		
Name of Patient/Gua	ardian						
		Tick this box to conf	firm all your details abo	ove are correct.	Date		
Hospital/Hospice							
Address							
Ward				Hospital No. (if know	vn)		
Date of Admission				Date of Discharge			

PLEASE SUBMIT AN ORIGINAL HOSPITAL DISCHARGE SUMMARY TO VERIFY YOUR HOSPITAL STAY. IF YOU ARE UNABLE TO PROVIDE A DISCHARGE SUMMARY WE WILL CONTACT THE HOSPITAL/HOSPICE ON YOUR BEHALF WHICH WILL CAUSE A DELAY IN THE SETTLEMENT OF YOUR CLAIM.



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### **Day Case Surgery / Treatment**

Patient Forename	Patient S	Surname	
Date of Birth	Policyholder	Spouse/Partner	Child under 18
Hospital			
Ward		<b>Date of Stay</b>	

This benefit is ONLY for planned day case surgery/treatment, NOT for emergency admissions for one day nor for outpatient appointments. Please attach a letter from the hospital confirming your day stay. If this is not available, please print this form and ask the hospital to provide the information in the section below.

Si	ignature of authorised hospital offic	BE COMPLETED BY THE HOSPITAL ure of authorised hospital official confirming day stay and occupancy of a bed. tient clinic appointments to be excluded:								1	C	ffici	al Ho	spi	tal S	itan	ıp	- 1
	1 1		Date							1								
	!!									-								-4
	Designation of above official															:		

in words



### **Other Categories**

### Receipts enclosed Totalling £

Full name(s) of person(s) to whom the receipt(s) refer(s):

#### THE RECEIPTS MUST:

- a) be originals, not photocopies; (credit/debit card receipts submitted on their own cannot be accepted)
- **b)** include the practitioner's stamp/name and date of issue;
- c) include the patient's name;
- d) state the type of service and items provided;
- e) be for a service covered by the HSF categories only and not for any insurance premiums paid to cover that service;
- f) be for a service for which payment has been met by a person registered under HSF health plan.

For a birth or adoption grant claim, you will need to submit/attach the original birth/adoption certificate. If submitting your claim by post, this will be returned to you. If you require a Special/Recorded service please include a self addressed envelope with the correct postage and completed official delivery label.

Receipts will not be returned unless requested.

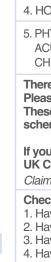
Should it be necessary for my claim to be verified, I authorise HSF health plan to approach the relevant clinical practitioner/hosptial/hospice and authorise them to supply information to enable my claim to be processed.

#### SIGN / TYPE NAME

**Enter your name** 

**Date** 

Tick this box to confirm all your details above are correct.



Please tick 

✓ the appropriate box to indicate HSE USE the nature of the claim(s). 1. BIRTH/ADOPTION GRANT 2. SPECIALIST/INVESTIGATIONS 3. DENTAL **OPTICAL** 4. HOME HELP 5. PHYSIOTHERAPY **OSTEOPATHY CHIROPRACTIC** ACUPUNCTURE **HOMOEOPATHY** CHIROPODY/PODIATRY **HEALTH SCREENING** There are different claim forms for Personal Accident benefits.

Please refer to brochure for details of injuries applicable. These include fracture/temporary disability (available on some schemes only) and permanent disability.

If you require one of these forms, please contact our office. UK Claims - 020 7202 1381 ROI Claims - 0818 473 473.

Claims should be made within 6 months.

- 1. Have you enclosed your receipts/hospital discharge summary?
- 2. Have you signed the form?
- 3. Have you completed all of the relevant sections?
- 4. Have you completed Pages 1 & 2?
- 5. Have you supplied / checked your bank account details?
- 6. Have you kept a copy of your claim form and receipts submitted for your records?