

**Date of Admission** 

# **Claim Form**

Please return or email this form to:

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

Ì	To complete your claim form online, please install <b>Adobe Acrobat Reader</b> then download, open and complete your claim form using this software
i	Click here to download

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ф То	be Com	oleted by t	the Policyh	older (All claims mu	ıst be made wi	thin 6 months.)	
_						HS	SF USE
Forename							
Surname							
Address				Postcode			
Policy No				Telephone Number			
Employer	(If premium	ns are deducted from	nav/nension)	Email Address			
In order to receive settle savings account) held in y	ement of you			bank details below. W	le can only cred	it a current accou	nt (not a
Account No:				Sort Co	ode:		-
Account Name:							
This section must be <b>cor</b> every continuing claim. N	•				and birth grant) a	and is also require	ed for
? Ple	ease ansv	wer the fo	llowing que	stions in full:			
1. What diagnosis has I If no diagnosis has b					e consultation	or for treatment	etc.?
2. When did symptoms	of this condi	tion/problem	first begin?	3. When was the fa	mily doctor firs	t consulted abou	ut them?
Ho	spital an	d Hospice					
B							
Patient Forename							
Patient Surname							
Date of Birth			Policyholder	Spouse/	Partner	Child under	
TO BE COMPLETED B I, the patient or guardian						Please ti	ick/select one
Name of Patient/Gua	ardian						
	Tic	k this box to confir	rm all your details abo	ve are correct.	Date		
Hospital/Hospice							
Address							
Ward				Hospital No. (if know	vn)		

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.

**Date of Discharge** 



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## **Day Case Surgery / Treatment**

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

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.

Signature of authorised hosp	TO BE COMPLETED BY THE HOSPITAL gnature of authorised hospital official confirming day stay and occupancy of a bed. utpatient clinic appointments to be excluded:				
	Date	[1] ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (			
Designation of above offi	icial				

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.

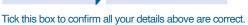
Receipts will not be returned unless requested.

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** 





HSF USE

- 1. BIRTH/ADOPTION GRANT
- 2. SPECIALIST/INVESTIGATIONS
- 3. DENTAL OPTICAL
- 4. HOME HELP

5. PHYSIOTHERAPY OSTEOPATHY
CHIROPRACTIC ACUPUNCTURE
HOMOEOPATHY CHIROPODY/PODIATRY

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.

#### Checklist

- 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?