CLAIM FORM

Please return this form to:
CLARE ROAD MALL
CLARE ROAD
ENNIS, CO. CLARE
Local RateTel: 1890 473 473
Fax: 065 6862504

R

C

All claims should be made within 6 months.
Visit **www.hsf.eu.com** to download another claim form and more information.

To be completed by the Contributor

A

HSF USE

BLOCK LETTERS PLEASE

Surname .....

Forenames .....

Address .....

..... SIGNATURE ×

Registration No .... DATE ×

If you wish to receive a Direct Credit Payment, please ensure the details below are correct (for security reasons only the last 4 digits of your account are noted), or please provide them if blank.

Payment Method – (*please tick box*)

☐ Direct Credit to Account No Sort Code

B

This section must be completed in full for all claims (except for dental / optical / GP / A&E / prescription / chiropody and birth grant) and is also required for every continuing claim.
Missing information may delay claim settlement.

Please answer the following questions in full:

1. What diagnosis has been given as the reason for the admission to hospital or for the consultation or for treatment etc.? If no diagnosis has been made, please describe your symptoms.

   .....

2. When did symptoms of this condition/problem first begin?

   .....

3. When was the family doctor first consulted about them?

   .....

4. Was the illness connected in any way with a previous one? YES/NO

   If yes, please state date of previous illness .....

C

Hospital and Hospice

Patient – Surname .....

Forenames .....

Date of Birth ..... CONTRIBUTOR☐ SPOUSE/PARTNER☐ CHILD UNDER 18☐

Please tick

TO BE COMPLETED BY THE PATIENT OR GUARDIAN OF CHILD UNDER THE AGE OF 18:

*Please delete as necessary

* I the patient/guardian of the named above, was an in-patient at the Hospital/Hospice mentioned below and authorise an official from that establishment to confirm the dates of my/my child's admission and discharge and to indicate to the HSF health plan the nature of my/the patient's illness by using one of the following categories: General, Geriatric, Psychiatric, Accident, Birth Grant-Ante/Post, Birth Grant - Confinement.

Signature (Patient or Guardian) × Date ×

Name of Hospital/Hospice .....

Address .....

Ward ..... Hospital No. (if known) .....

Date of Admission ..... Date of Discharge .....

PLEASE NOTE – HSF HEALTH PLAN WILL CONTACT THE HOSPITAL OR HOSPICE, YOU DO NOT HAVE TO.
HOWEVER IF YOU HAVE AN ORIGINAL HOSPITAL DISCHARGE CERTIFICATE PLEASE ENCLOSE IT.

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D Day Case Surgery/Treatment

This benefit is ONLY for planned day case surgery/treatment, NOT for emergency admissions for one day nor for outpatient appointments.

Patient - Surname .....

Forenames .....

Date of Birth ..... CONTRIBUTOR☐ SPOUSE/PARTNER☐ CHILD UNDER 18☐
Please tick

Name of Hospital .....

Ward ..... Date of Stay .....

* To be completed by the hospital *	
Signature of authorised hospital official confirming day stay & occupancy of a bed: Designation of above official	Official stamp of hospital

E Other Categories

RECEIPTS ENCLOSED TOTALLING €

(In words……)

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

The receipts, which will be returned, must:

a) be originals, not photocopies;
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 for which payment has been met by a person registered under HSF health plan;
f) be for a service covered by the HSF categories only and not for any insurance premiums paid to cover that service.

For a birth or adoption grant claim, please enclose an original Birth / Adoption Certificate. The certificate will be returned to you.

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

SIGNATURE OF CONTRIBUTOR ✘

DATE ✘

Please tick the appropriate box to indicate the nature of the claim(s).	HSF USE
1. BIRTH / ADOPTION GRANT ☐	
2. SPECIALIST/INVESTIGATIONS ☐	
3. DENTAL/OPTICAL ☐	
4. SURGICAL APPLIANCES/ HEARING AIDS ☐	
5. PHYSIOTHERAPY ☐ OSTEOPATHY ☐ CHIROPRACTIC ☐ ACUPUNCTURE ☐ HOMOEOPATHY ☐ CHIROPODY ☐	
6. GP/ A&E DEPARTMENT/ PRESCRIPTIONS (selected Schemes only) ☐	
There are special claim forms for: FRACTURE/ TEMPORARY DISABILITY ☐ PERMANENT DISABILTY ☐ Please refer to brochure for details of injuries applicable and tick box to request form. (Scheme €2050 and above only)	
Checklist: **1. Have you enclosed your receipts?** **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 completed or checked your bank details are correct?**	

Please complete Page 1