HSF health plan®

Please return this form to:
Clare Road Mall
Clare Road
Ennis, Co Clare.

LoCall 1890 473 473
Fax 065 6862504

Claim Form

Thank you for notifying us of your claim. ***All claims must be made within 6 months.***
PLEASE USE BLACK INK AND BLOCK CAPITAL LETTERS AND ENSURE YOU SIGN THE DECLARATION ON THIS FORM.

To be completed by the Contributor

A

Surname _____

Forenames _____

Address _____

_____ Postcode _____

Daytime Telephone _____ Email _____

HSF USE

Registration No _____ **Signature** _____

Employer _____ **Date** _____

(*If contributions are deducted from pay/pension*)

Payment of your claim will normally be made directly to your Bank/Building Society account. Please give details:

Name of the account holder(s) _____

Account Number | | | | | | | | | Sort Code | | – | | | – | | |

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.

B

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 _____

Hospital and Hospice

C

Patient – Surname _____ Forenames _____

Date of Birth _____ Contributor ☐ Spouse/Partner ☐ Child under 18 ☐

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.

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.
PLEASE ATTACH A COPY OF YOUR DAY CASE NOTIFICATION LETTER (if available).

D

Patient Surname _____

Forenames _____

Date of Birth _____ Contributor ☐ Spouse/Partner ☐ Child under 18 ☐

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. Outpatient clinic appointments to be excluded:

_____

Designation of above official _____

Official Stamp of Hospital

Other Categories

E

Receipts enclosed Totalling € _____

In words _____

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, please enclose an original full Birth/Adoption Certificate which will be returned to you promptly by post.
(if you require a Special/Recorded service please include a self addressed envelope with the correct postage and completed official delivery

Receipts will not be returned unless requested.
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. GP VISIT ☐ **PRESCRIPTION CHARGE** ☐ **A&E VISIT** ☐	
2. SPECIALIST/INVESTIGATIONS ☐ **CONSULTATIONS** ☐ **HEALTH SCREENING** ☐	
3. DENTAL / OPTICAL ☐	
4. BIRTH / ADOPTION GRANT ☐	
5. PHYSIOTHERAPY ☐ **OSTEOPATHY** ☐ **CHIROPRACTIC** ☐ **ACUPUNCTURE** ☐ **HOMOEOPATHY** ☐ **CHIROPODY** ☐	
6. SURGICAL APPLIANCES / HEARING AIDS ☐	
There are special claim forms for: **FRACTURE / TEMPORARY DISABILITY** ☐ **PERMANENT DISABILITY** ☐ *Please refer to brochure for details of injuries applicable and tick box to request form. (Scheme €4.25 / €20.50 and above only). Claims should be made within 3 months.*	
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?**	