ONE SCHEME CLAIM FORM

Please return this form to:
5 WESTGATE BUSINESS PARK
KILRUSH ROAD
ENNIS, CO. CLARE
LoCall Tel: 1890 473 473
Fax: 065 6862504

P

C

All claims must be made within 6 months.
Visit **www.hsf.ie** to download another claim form and for more information.

A

To be completed by the Policyholder

HSF USE

BLOCK LETTERS PLEASE

Surname ....

Forenames ....

Address ....

.... Postcode ....

Policy No .... Daytime Telephone ....

Employer .... Email ....

(If contributions are deducted from pay/pension)

If you would like to receive payment direct into the bank, then please complete your account details. We can only credit a **current** account (not a savings account) held in **your** name.

IBAN: | | | | | | | | | **BIC:** | | | | | | | | | | | |

Account Name: ....

B

This section must be <u>completed in full for all claims</u> (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? ....

C

Hospital and Hospice

Patient – Surname ....

Forenames ....

Date of Birth ....

TO BE COMPLETED BY THE PATIENT :

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

Signature (Patient) ✘ 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.

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. Please attach a copy of your day case notification letter if available.

Patient - Surname ....

Forenames ....

Please complete Page 2

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Date of Birth .....

Name of Hospital .....

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

* To be completed by the hospital *	
Signature of authorised hospital official confirming day stay and occupancy of a bed. Outpatient clinic appointments to be excluded: ..... Date..... Designation of above official	Official Hospital Stamp

E Other Categories

RECEIPTS ENCLOSED TOTALLING € (in words.....)

Please tick the appropriate box to indicate the nature of the claim(s)	HSF USE
1. GP VISIT ☐ PRESCRIPTION CHARGE ☐ A&E VISIT ☐	
2. OPTICAL TREATMENTS ☐ **PLEASE NOTE due to Tax Relief at Source we cannot pay any claims if this section is not completed. Please only tick ONE box which represents the main treatment you received.** **DENTAL TREATMENTS**: ROUTINE CHECKUP & SCALING/FILLING OF TEETH ☐ EXTRACTION ☐ PROVISION/REPAIRING OF ARTIFICIAL TEETH/DENTURES ☐ CROWNS ☐ TIP REPLACING ☐ VENEERS/REMBRANT TYPE ETCHED FILLINGS ☐ GOLD POSTS ☐ GOLD INLAYS ☐ BRIDGEWORK ☐ ENDODONTICS – ROOT CANAL TREATMENT ☐ PERIOODONTAL TREATMENT/DENTAL IMPLANTS ☐ ORTHODONTIC TREATMENT ☐ HOSPITAL SURGICAL EXTRACTION OF IMPACTED WISDOM TEETH ☐	
3. MEDICAL TESTS ☐ 4. CONSULTATIONS ☐ 5. BIRTH/ADOPTION GRANT ☐	
6. PHYSIOTHERAPY ☐ PHYSICAL THERAPY ☐ CHIROPRACTIC ☐ OSTEOPATHY ☐ ACUPUNCTURE ☐ HOMEOPATHY ☐ CHIROPODY ☐	
There are special claim forms for: FRACTURE/TEMPORARY DISABILITY AND PERMANENT DISABILITY Please refer to your brochure and contact us on 1890 473 473 for details on claims under this category	

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;

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 label).

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 POLICYHOLDER ✘

DATE ✘

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?

Please complete Page 1