



Claim Form

Please return or email this form to:

5 WESTGATE BUSINESS PARK,
KILRUSH ROAD ENNIS, CO. CLARE,
Tel: 0818 473 473
Email: claims@hsf.ie

To complete your claim form online,
please install **Adobe Acrobat Reader**
then download, open and complete
your claim form using this software

[Click here to download](#)

P

C

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

HSF USE



CAPITAL LETTERS PLEASE Visit www.hsf.ie to download another claim form and more information.

Forename		Surname	
Address		Eircode	
Policy No		Telephone Number	
Employer		Email Address	

(If premiums are deducted from pay/pension)

In order to receive settlement of your claim, please provide your bank details below. We can only credit a current account (not a savings account) held in your name.

IBAN:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
BIC:	<input type="text"/>	Account Name:	<input type="text"/>	

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?

C Hospital and Hospice

Patient Forename	<input type="text"/>		
Patient Surname	<input type="text"/>		
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>

▼ TO BE COMPLETED BY THE PATIENT:

I, the patient named above, was an in-patient at the Hospital/Hospice mentioned below.

Name of Patient	<input type="text"/>		
	Tick this box to confirm all your details above are correct. <input type="checkbox"/>		Date <input type="text"/>
Hospital/Hospice	<input type="text"/>		
Address	<input type="text"/>		
Ward	<input type="text"/>	Hospital No. (if known)	<input type="text"/>
Date of Admission	<input type="text"/>	Date of Discharge	<input type="text"/>

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.

D Day Case Surgery / Treatment

Patient Forename		Patient Surname	
Date of Birth		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.

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:

Designation of above official

Date

Official Hospital Stamp

E Other Categories

Receipts enclosed Totalling € in words

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

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.			
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 PERIODONTAL 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	ACUPUNCTURE OSTEOPATHY
CHIROPODY			HOMEOPATHY
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.			

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.

SIGN / TYPE NAME

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

Enter your name

Date

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

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?