



# 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](http://www.hsf.ie) to download another claim form and more information.

Forename		Surname	
Address		Eircode	
Policy No		Telephone Number	
Employer		Email Address	

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"/>	Policyholder	<input type="text"/>	Spouse/Partner	<input type="text"/>	Child under 21	<input type="text"/>

Please tick/select one

### ▼ TO BE COMPLETED BY THE PATIENT OR GUARDIAN OF CHILD UNDER THE AGE OF 21:

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

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

Date

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		Policyholder		Spouse/Partner		Child under 21	
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:

Date

Designation of above official

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. SURGICAL APPLIANCES/HEARING AIDS	6. BIRTH/ADOPTION GRANT
7. PHYSIOTHERAPY	PHYSICAL THERAPY	CHIROPRACTIC	ACUPUNCTURE    OSTEOPATHY    CHIROPODY
PODIATRY		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.

**▼ 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?