medicash

A positive approach to health

- Please include your Medicash Policy Number
- Mark your choices in the boxes with a cross (X)
- Please do not use a photocopy of this form
- Please do not write over the edges of the boxes
- Please write carefully using BLOCK CAPITALS in BLACK INK and do not use staples
- Please sign the claim form at the bottom of this page
- Any errors or omissions may result in a delay in the processing of your claim

Once complete, please return this form to:
Medicash, One Derby Square, Liverpool L2 1AB

If you have a query please contact us on **0151 702 0265** or **email claims@medicash.org**
Telephone lines are open Monday to Thursday 8.45am to 5pm and Friday 8.45am to 4pm (excluding public holidays).

Part 1 - Policyholder Details

If your personal details have changed please contact us prior to making a claim.

To have claims paid directly into your bank account, or if you have changed bank account, call **0151 702 0265** or visit **www.medicash.org/paperless**

Medicash Policy Number:

Title: Mr / Mrs / Ms / Miss / Other:

Surname:

Forename(s):

Date of Birth: / /

Address:

Postcode:

Daytime Tel. No.

Email:

Please use this email address for all future: Policy updates ☐ Claims queries & confirmations ☐

Part 2 - Your Claims

Please place a cross (X) in the box to identify the claimant and benefit being claimed. Please complete a separate line for each receipt, up to a maximum of 4 receipts per claim form (see example below). You can use this form to claim more than one type of benefit. **Please ensure that you enclose all the relevant, original receipts with this claim form.** If you have had a series of treatments the receipt must show the date and cost for each treatment.

Receipted Benefits:

Claimant: Policyholder	Partner	Child	Benefit: Optical	Dental	Physio	Chiropractic	Other	Amount of Receipt: £	Date of Receipt: D D / M M / Y Y Y Y
X						X		100.00	11 / 09 / 2015
								£ .	/ / 20
								£ .	/ / 20
								£ .	/ / 20
								£ .	/ / 20

Private Medical Insurance (PMI) Excess Fees:

Part 3 overleaf must be completed for PMI Excess claims.

Claimant: Policyholder	Partner	Child	Amount of Receipt: £	Date: / / 20
			.	

Hospital Benefits:

Part 4 overleaf must be completed by the ward clerk for ALL claims for hospital inpatient and daycase treatment.

Claimant: Policyholder	Partner	Child	Type of Hospital Stay: Inpatient	Daycase	Parental Stay

Birth/Adoption of a Child:

☐ Please place a cross (X) in the box to claim this benefit and attach the full original birth certificate(s). If you are making a claim for an adopted child please attach the adoption papers including the placement order.

Declaration: I hereby declare that the information given by me in relation to this claim is complete and accurate and I give my permission to Medicash to make any reasonable enquiries that it deems necessary to validate this claim.

Signature:

Date: / /

NB: To protect all members, Medicash will take action against anyone who makes a dishonest or false claim. Such actions could include, but are not limited to, refusal to accept liability to pay a claim, termination of your policy or legal action. To detect and prevent fraud or improper claims we may check your details with fraud protection agencies. If we reasonably suspect fraud, we will record and investigate this, including working with other organisations and other insurers to pool applications or claims which are believed to be fraudulent and may contact the police.

Medicash is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

Part 3 - Private Medical Insurance (PMI) Excess Fees

Please refer to your Benefit Table and Policy Schedule to ensure Private Medical Insurance Excess Fees are covered under your policy, before making a claim. Please note that this benefit is not covered on all plans.

Have you paid the practitioner? Yes ☐ No ☐ Make payment for this claim to: Policyholder ☐ Practitioner ☐

If this is to be paid directly to your practitioner please enter their details below:

Make cheque payable to:

Practitioner Address:

Please enclose a copy of your PMI statement from your PMI insurer to support this claim.

Part 4 - Hospital Inpatient and Daycase Claims - patient details

TO BE COMPLETED BY THE WARD CLERK

This section must be completed by the ward clerk for **ALL** claims for hospital treatment. Please ensure that the hospital stamps your form and a hospital official has signed and dated where applicable. Alternatively, please enclose proof of your hospital stay with a MED10 Certificate or Hospital Discharge Note.

Patient's Title: Mr / Mrs / Ms / Miss / Other:

Patient's Forename(s):

Patient's Surname:

Date of Birth: / /

The patient was admitted for the following treatment:

Inpatient ☐ Daycase ☐

If the patient attended A&E immediately prior to admission please state the date and time of admission:

Date: Time:

Treatment Dates:

Admission Date(s):	Discharge Date(s):	Number of Nights:

Home Leave:

Has the patient been on home leave? Yes ☐ No ☐

From: To:

From: To:

Confirmation:

Authorised Signature:

Date: Position:

Hospital Stamp:

Parental Stay:

Please complete if a parent / guardian has accompanied a child under 12 during an Inpatient Stay.

Number of Nights:

Name of Accompanying Adult:

Hospital Transfers

This section must be completed by the hospital.
I confirm that the above named patient was transferred from the hospital named above and treated as an inpatient at this hospital.

Admission Date(s):	Discharge Date(s):	Number of Nights:

Home Leave:

Has the patient been on home leave? Yes ☐ No ☐

From: To:

From: To:

Confirmation:

Authorised Signature:

Date: Position:

Hospital Stamp:

Please ensure you have completed Part 1 and signed the declaration on the front of this form.

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