HEALTHSHIELD
WE'VE GOT YOU COVERED

FOR OFFICE USE ONLY

PLEASE USE BLOCK LETTERS

PLEASE REFER TO YOUR MEMBERSHIP PLAN WHEN CLAIMING BENEFITS. PLEASE MAKE SURE YOU COMPLETE YOUR MEMBER NUMBER AS YOUR CLAIM COULD BE DELAYED.
PLEASE SEE REVERSE FOR HOSPITAL CLAIMS

1 MEMBER'S PERSONAL INFORMATION

PLEASE CIRCLE: MR, MRS, MS, MISS, OTHER ________

SURNAME

FORENAME(S)

DATE OF BIRTH DD / MM / YY

MEMBER NUMBER
YOU CAN USE YOUR MEMBER NUMBER TO VISIT www.healthshield.co.uk AND CHECK YOUR BENEFIT ALLOWANCES ONLINE

FULL POSTAL ADDRESS

POSTCODE

CONTACT EMAIL ADDRESS (PLEASE USE BLOCK LETTERS)

CONTACT TELEPHONE NUMBER

EMPLOYMENT COMPANY DETAILS (IF APPLICABLE)

PAY OR EMPLOYEE NUMBER (IF APPLICABLE)

2 RECEIPT BASED CLAIM DETAILS A SAMPLE RECEIPT IS SHOWN ON THE REVERSE OF THIS FORM

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.

I AM CLAIMING FOR:

YOU	PARTNER	CHILD	DATE OF BIRTH	BENEFIT	AMOUNT PAID	DATE OF TREATMENT	MEDICAL REASON FOR TREATMENT
			DD / MM / YY			DD / MM / YY	
			DD / MM / YY			DD / MM / YY	
			DD / MM / YY			DD / MM / YY	
			DD / MM / YY			DD / MM / YY	

IF APPLICABLE, I ENCLOSE A COPY OF MY NEWBORN BABY'S **FULL** BIRTH CERTIFICATE ☐

FOR HOSPITAL CLAIMS PLEASE SEE THE REVERSE OF THIS FORM

FOR DENTAL ACCIDENT CLAIMS PLEASE ALSO SEE SECTION 4

3 METHOD OF BENEFIT PAYMENT

HOW DO YOU WISH THIS PAYMENT TO BE MADE? **(✓ TICK AS APPLICABLE)**

CHEQUE SEE (A) ☐ EXPRESS DIRECT CREDIT SEE (B) ☐

(A) CHEQUES TO BE MADE PAYABLE TO (IF DIFFERENT FROM THE MEMBER)

PLEASE TICK IF YOU DON'T WISH YOUR DIRECT CREDIT NOTIFICATION TO BE SENT BY EMAIL ☐

PLEASE CIRCLE: MR, MRS, MS, MISS, OTHER ________

SURNAME

FORENAME(S)

(B) COMPLETE THIS SECTION TO BE PAID BY DIRECT CREDIT (IF YOU HAVE ALREADY PROVIDED THESE DETAILS THEN THERE IS NO NEED TO FILL THEM IN AGAIN UNLESS YOUR ACCOUNT DETAILS HAVE ALTERED)

BANK/BUILDING SOCIETY NAME

ACCOUNT NUMBER

SORT CODE

4 FOR DENTAL ACCIDENT CLAIMS ONLY (THIS SECTION MUST BE COMPLETED BY YOUR DENTIST)

DATE OF ACCIDENT

PATIENT'S NAME

SIGNATURE OF DENTIST

CAUSE OF ACCIDENT

OFFICIAL STAMP OF DENTIST

PLEASE ENCLOSE THE RECEIPT FROM THE DENTIST CONFIRMING THE TREATMENT HAS BEEN CAUSED BY A DIRECT BLOW TO THE HEAD

5 MEMBER'S AUTHORISATION AND SIGNATURE

I GIVE MY CONSENT TO ALL PROCESSING OF PERSONAL AND SENSITIVE DATA.
I DECLARE THAT ALL THE INFORMATION INCLUDED IS ACCURATE, TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.
I AGREE THAT HEALTH SHIELD CAN CONFIRM THE DETAILS WITH THE HEALTHCARE PROVIDER.

DATE DD / MM / YY

YOUR SIGNATURE

FRAUDULENT CLAIMS: IN THE INTEREST OF OUR MEMBERS, DETECTION OF FRAUDULENT CLAIMS COULD RESULT IN LEGAL ACTION.

6 HOSPITAL CLAIMS

THE MEMBER MUST FILL IN SECTION 6. THIS MUST THEN BE CHECKED, SIGNED AND STAMPED AT THE HOSPITAL, REGISTERED TREATMENT CENTRE OR HOSPICE. ALTERNATIVELY, PLEASE ENCLOSE PROOF OF YOUR HOSPITAL STAY BY SENDING YOUR INPATIENT LETTER. PLEASE ALLOW 2 TO 3 WEEKS WHEN CLAIMING THESE BENEFITS.

PLEASE CIRCLE	PATIENT'S SURNAME	PATIENT'S FORENAME(S)
MR, MRS, MS, MISS, OTHER ________		

✓ **(TICK AS APPLICABLE)**

WAS ADMITTED AS AN INPATIENT ☐ WAS ADMITTED AS A DAY-SURGERY PATIENT ☐ PARENT ACCOMPANYING CHILD OVERNIGHT ☐

AND WAS GIVEN ANAESTHETIC? YES ☐ NO ☐ NAME OF PARENT ________

ADMISSIONS	DATE ADMITTED	DATE DISCHARGED	NUMBER OF DAY CASE/ OVERNIGHT STAYS	PATIENT'S HOSPITAL NUMBER IF KNOWN
1ST ADMISSION	DD / MM / YY	DD / MM / YY		
2ND ADMISSION	DD / MM / YY	DD / MM / YY		

HAS THE PATIENT BEEN ON HOME LEAVE? YES ☐ NO ☐ IF **'YES'**, STATE DATES ________

HAS THE PATIENT PREVIOUSLY BEEN ADMITTED FOR THIS CONDITION? YES ☐ NO ☐

I CERTIFY THAT THE PATIENT WAS ADMITTED ON THESE DATES FOR THE FOLLOWING MEDICAL CONDITION(S) DETAILED BELOW

OFFICIAL STAMP OF HOSPITAL, REGISTERED TREATMENT CENTRE OR HOSPICE

POSITION OF AUTHORISED OFFICIAL

SIGNATURE OF AUTHORISED OFFICIAL

DATE

DD / MM / YY

7 FOR MATERNITY - ANTENATAL APPOINTMENT AND ADOPTION CLAIMS ONLY

THIS SECTION MUST BE COMPLETED BY THE G.P. SURGERY, HOSPITAL, REGISTERED CLINIC OR SERVICE IF CLAIMING MATERNITY - ANTENATAL. IF MAKING A CLAIM FOR ADOPTION OF A CHILD AGED THREE OR YOUNGER PLEASE ATTACH A COPY OF THE ADOPTION PAPERS.

DATE OF SCAN

DD / MM / YY

HOW MANY WEEKS PREGNANT

PATIENT'S NAME

SIGNATURE OF AUTHORISED OFFICIAL

OFFICIAL STAMP OF G.P. SURGERY. HOSPITAL, REGISTERED CLINIC OR SERVICE

CLAIMS CHECKLIST

- ✔ **HAVE YOU SIGNED AND DATED SECTION 5?**
- ✔ **HAVE YOU INCLUDED YOUR MEMBERSHIP NUMBER?**
- ✔ **HAVE YOU COMPLETED SECTION 3?**
- ✔ **HAVE YOU ATTACHED THE RELEVANT RECEIPTS, CERTIFICATES OR PAPERS?**
- ✔ **IF RELEVANT, HAS THE HOSPITAL CHECKED AND SIGNED SECTION 6?**

PLEASE RETURN TO

PLEASE RETURN THIS FORM, ALONG WITH ALL NECESSARY ADDITIONAL INFORMATION AND RECEIPTS TO HEALTH SHIELD. WE AIM TO TURNAROUND ALL RECEIPT BASED CLAIMS WITHIN TWO WORKING DAYS. PLEASE NOTE, THE RETURN HEALTH SHIELD ADDRESS IS POSITIONED FOR A STANDARD WINDOW ENVELOPE, IF YOU WISH TO USE ONE.

Health Shield Friendly Society Ltd
Electra Way, Crewe Business Park
Crewe, Cheshire
CW1 6HS

SAMPLE RECEIPT FOR GUIDANCE

Name and qualifications of practitioner

Name of person who had treatment

Details of treatment including date, description of treatment and cost

Physiotherapy Clinic
HPC registered
123 High Road, Anytown,
AA1 1AA
Tel: 01234 000000

MR AN OTHER, 11 HIGH ST,
ANYTOWN, A1 2HS

03/07/10 TREATMENT £20.00
10/08/10 TREATMENT £20.00
14/09/10 TREATMENT £20.00

RECEIPT PAID IN FULL
07/10/10

INVESTORS IN PEOPLE

As part of our on-going quality control programme, calls may be monitored or recorded. The paper in this literature is made from sustainable certified forests.

BCF A/JANUARY2011