

Claim Form

Please return this claim form by post to:

5 WESTGATE BUSINESS PARK,
KILRUSH ROAD ENNIS, CO. CLARE,
Tel: 0818 473 473

Alternatively, you can register or log in to your mypolicy account at www.mypolicy.hsf.eu.com to submit your **claim online**.

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	

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

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.

Name of Patient/Guardian	<input type="text"/>
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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.

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Day Case Surgery / Treatment

Patient Forename		Patient Surname	
Date of Birth		Policyholder	<input type="checkbox"/>
		Spouse/Partner	<input type="checkbox"/>
		Child under 21	<input type="checkbox"/>
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:

Official Hospital Stamp

Designation of above official

Date

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	
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. SPECIALIST/INVESTIGATIONS		
4. PHYSIOTHERAPY	OSTEOPATHY	CHIROPRACTIC ACUPUNCTURE CHIROPODY HEALTH SCREENING

THE RECEIPTS MUST:

- a) be the original or good copies; (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.

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.

SIGN / TYPE NAME

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?