

6 HOSPITAL INPATIENT, DAY-CASE ADMISSIONS AND PARENTAL HOSPITAL STAY

YOU MUST FILL IN SECTION 6 YOURSELF. THIS MUST THEN BE CHECKED, SIGNED AND STAMPED AT THE HOSPITAL, REGISTERED TREATMENT CENTRE OR HOSPICE. 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 OR WAS ADMITTED AS A DAY-CASE PATIENT OR PARENT ACCOMPANYING CHILD OVERNIGHT

AND WAS GIVEN ANAESTHETIC? YES NO

NAME OF PARENT _____

NAME OF HOSPITAL

PATIENT'S HOSPITAL NUMBER IF KNOWN

ADMISSIONS

DATE ADMITTED

DATE DISCHARGED

NUMBER OF DAY CASE/OVERNIGHT STAYS

1ST ADMISSION

2ND ADMISSION

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

7 FOR MATERNITY - ANTENATAL APPOINTMENT CLAIMS ONLY

(THIS SECTION MUST BE COMPLETED BY THE G.P. SURGERY, HOSPITAL, REGISTERED CLINIC OR SERVICE)

DATE OF SCAN

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

PATIENT'S NAME

SIGNATURE OF AUTHORISED OFFICIAL

8 MEMBER'S EMPLOYMENT DETAILS (IF APPLICABLE)

COMPANY

PAY OR EMPLOYEE NUMBER

CLAIMS CHECKLIST

- | | |
|--|---|
| <input type="checkbox"/> HAVE YOU INCLUDED YOUR MEMBER NUMBER? | <input type="checkbox"/> ARE YOU CLAIMING THE DENTAL ACCIDENT BENEFIT? IF YES, HAS YOUR DENTIST COMPLETED AND SIGNED SECTION 4? |
| <input type="checkbox"/> HAVE YOU ATTACHED ALL THE RELEVANT ORIGINAL RECEIPTS FOR EACH PERSON? | <input type="checkbox"/> ARE YOU SENDING A HOSPITAL CLAIM FORM? PLEASE CHECK THE FORM HAS BEEN FULLY COMPLETED. |
| <input type="checkbox"/> IF CLAIMING THE PHYSIOTHERAPY ETC, SPECIALIST CONSULTATION, HEALTH AND WELLBEING OR FAMILY PLANNING BENEFIT, HAVE YOU COMPLETED SECTION 2 FULLY STATING THE MEDICAL REASONS FOR THE TREATMENT AND/OR TESTS? | <input type="checkbox"/> IF CLAIMING MATERNITY - ANTENATAL APPOINTMENT BENEFIT, HAS SECTION 7 BEEN FULLY COMPLETED? |
| <input type="checkbox"/> HAVE YOU INCLUDED A FULL BIRTH CERTIFICATE FOR THE BABY IF CLAIMING MATERNITY BENEFIT? | <input type="checkbox"/> HAVE YOU SIGNED AND DATED SECTION 5? |

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

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Telephone: 01270 588555 Fax: 01270 251366 Opening hours: 8.00am to 6.00pm, Monday to Friday Email: info@healthshield.co.uk Website: www.healthshield.co.uk

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