

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 discharge letter or discharge summary. Please allow 2 to 3 weeks when claiming these benefits.

Title (Please Circle): Mr, Mrs, Ms, Miss, Other

Name of hospital

Patient's surname

Patient's forename(s)

Patient's hospital number (if known)

<p>The patient was admitted for the following treatment</p> <p>Inpatient <input type="checkbox"/> Day-surgery patient <input type="checkbox"/> given anaesthetic or sedation <input type="checkbox"/></p> <p>Maternity-related <input type="checkbox"/> Respite care <input type="checkbox"/></p> <p>✓ (Tick as applicable)</p>	<p>Parental stay</p> <p>Name of parent accompanying child overnight <input type="text"/></p> <p>No. of nights <input type="text"/> Dates: From <input type="text" value="DD/MM/YY"/> To <input type="text" value="DD/MM/YY"/></p>
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Admissions				Has the patient been on home leave? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date admitted	Date discharged	Number of days	Number of nights	
<input type="text" value="DD/MM/YY"/>	<input type="text" value="DD/MM/YY"/>	<input type="text"/>	<input type="text"/>	If 'yes' please state dates <input type="text"/>
<input type="text" value="DD/MM/YY"/>	<input type="text" value="DD/MM/YY"/>	<input type="text"/>	<input type="text"/>	
<input type="text" value="DD/MM/YY"/>	<input type="text" value="DD/MM/YY"/>	<input type="text"/>	<input type="text"/>	
<input type="text" value="DD/MM/YY"/>	<input type="text" value="DD/MM/YY"/>	<input type="text"/>	<input type="text"/>	
<p>Has the patient previously been admitted for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/></p>				
<p>Medical condition</p> <input type="text"/>				

I certify that the patient was admitted on these dates for the medical condition(s) detailed above

Official stamp of hospital, registered treatment centre or hospice

Position of authorised official

Signature of authorised official

Date

7. For Maternity - Antenatal Appointment and Adoption Claims Only

This section must be completed by the G.P. surgery or hospital if claiming maternity - antenatal. If making a claim for adoption of a child aged sixteen or younger please attach a copy of the adoption order.

Date of scan

How many weeks pregnant at scan date

Patient's name

Signature of authorised official

Official stamp of G.P. surgery or hospital

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.

Claims checklist

- ✓ Have you signed and dated section 5?
- ✓ Have you included your membership number?
- ✓ Have you completed sections 2 and 3?
- ✓ Have you attached the relevant receipts, certificates or papers?
- ✓ If relevant, has the hospital checked, stamped and signed section 6?
- ✓ Is your treatment date less than 12 months ago?
- ✓ Have you read the terms & conditions relevant to the benefit you are claiming?

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Established in 1877. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

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.

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