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.

1. Member's Personal Details

Member number

You can use your member number or email address to check your benefit allowances and submit receipt-based claims online by visiting the Members' Area on our website www.healthshield.co.uk

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

Surname

Forename(s)

Date of birth DD / MM / YY

Address

Postcode

Telephone number

Personal email

I want to be paperless, please send all my Health Shield membership information by email

2. Your Claims

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. Please also refer to the 'How to Claim' section on our website for full receipt details. If claiming for a private medical insurance (PMI) excess fee please also refer to Section 4.

I am claiming for

Forename	You	Partner	Child	Date of birth	Benefit	Amount paid	Treatment date	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	

For hospital & maternity claims please see the reverse of this form

Please indicate here if you are claiming for these benefits Yes ☐ No ☐

3. Benefit Payment Direct to your Bank Account

Please enter your bank details below. If you have already provided these details then there is no need to fill them in again unless your account details have altered, or we hold more than one account on your policy. We no longer pay benefit by cheque. If this is a problem then please contact us on 01270 588555.

Bank/Building society name

Account number

Sort code

4. Private Medical Insurance (PMI) Excess Fees

Before making a claim please refer to your membership plan to ensure that excess fees are covered under your policy.

If this is to be paid directly to your practitioner please enter their details below (if these details are not clear or not completed fully the payment will be made to you):

Make cheque payable to:

Practitioner address:

Please enclose a copy of your PMI claim statement from your PMI insurer to support this claim and please make sure you have also completed Section 2 above.

5. Member's Authorisation and Signature

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 practitioner.
I understand that Health Shield may end my membership if my claim is found to be fraudulent.

Your signature

Date DD / MM / YY

Fraudulent claims – Health Shield are committed to preventing financial crime and we will report to the police all instances of fraud or attempted fraud.

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

Patient's surname

Patient's forename(s)

Name of hospital

Patient's hospital number (if known)

The patient was admitted for the following treatment

Inpatient ☐ Day-surgery patient ☐ given anaesthetic or sedation ☐

Maternity-related ☐ Respite care ☐

✓ **(Tick as applicable)**

Parental stay

Name of parent accompanying child overnight

No. of nights ☐ Dates: From DD / MM / YY To DD / MM / YY

Admissions

Date admitted	Date discharged	Number of days	Number of nights
DD / MM / YY	DD / MM / YY		
DD / MM / YY	DD / MM / YY		
DD / MM / YY	DD / MM / YY		
DD / MM / YY	DD / MM / YY		

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

If **'yes'** please state dates

Has the patient previously been admitted for this condition? Yes ☐ No ☐

Medical condition

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

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 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 DD / MM / YY

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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