+medicash
A positive approach to health

- Please include your Medicash Policy Number
- Mark your choice in the boxes with a cross (X)
- Please do not use a photocopy of this form
- Please do not write over the edge of the boxes
- Please do not use staples
- Please sign the claim form in Part 1
- Any errors or omissions may result in a delay in the processing of your claim

Once complete, please return this form to:
Medicash, One Derby Square, Liverpool L2 1AB

If you have a query please contact us on **0151 702 0265** or **email claims@medicash.org**
Telephone lines are open Monday to Thursday 8.45am to 5pm and Friday 8.45am to 4pm (excluding public holidays).

Part 1 - Policyholder Details

If your personal details have changed please contact us prior to making a claim.

To have claims paid directly into your bank account, or if you have changed bank account, call **0151 702 0265** or visit **www.medicash.org/paperless**

Medicash Policy Nmber:

Title: Mr Mrs Ms Miss Other

Surname:

Forename(s):

Date of Birth: / /

Address:

Postcode:

Daytime Tel.No.

Email:

Please use this email address for all future: Policy information ☐ Claims queries & confirmations ☐

Declaration: I hereby declare that the information given by me in relation to this claim is complete and accurate and I give my permission to Medicash to make any reasonable enquiries that it deems necessary to validate this claim.

Signature:

Date: / /

NB: To protect all members, Medicash will take action against anyone who makes a dishonest or false claim. Such actions could include, but are not limited to, refusal to accept liability to pay a claim, termination of your policy or legal action. To detect and prevent fraud or improper claims we may check your details with fraud protection agencies. If we reasonably suspect fraud, we will record and investigate this, including working with other organisations and other insurers to pool applications or claims which are believed to be fraudulent and may contact the police.

Part 2 - Your Claims

Please place a cross (X) in the box to identify the claimant and benefit being claimed. Please complete a separate line for each receipt, up to a maximum of 4 receipts per claim form (see example below). You can use this form to claim more than one type of benefit. **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:

Claimant:			Receipted benefits:				Non-receipted benefits:	
Policyholder	Partner	Child	Optical/Dental	PMI Excess	Other	Amount being claimed:	Hospital	Birth of Child
☐	☐	☐	☐	☐	☐	£ .	☐	☐
☐	☐	☐	☐	☐	☐	£ .	☐	☐
☐	☐	☐	☐	☐	☐	£ .	☐	☐
☐	☐	☐	☐	☐	☐	£ .	☐	☐

Total number of receipts submitted:

If making a Private Medical Insurance Claim **please complete Part 3** below.

If making a Hospital Inpatient or Daycase claim **please complete Part 4** on the reverse of the form.

Part 3 - Private Medical Insurance (PMI) Excess Fees

Please refer to your Benefit Table and Policy Schedule to ensure Private Medical Insurance Excess Fees are covered under your policy, before making a claim. Please note that this benefit is not covered on all plans.

Have you paid the practitioner? Yes ☐ No ☐ Make payment for this claim to: Policyholder ☐ Practitioner ☐

If this is to be paid **directly** to your practitioner please enter their details below:

Make cheque payable to:

Practitioner Address:

Please enclose a copy of your PMI statement from your PMI insurer to support this claim. This will show the date of your treatment, what your insurer has paid and what is owed by you as a result of your policy excess. Your claim cannot be paid without this information.

Part 4 - Hospital Inpatient and Daycase Claims - Patient Details

This section must be completed by the ward for ALL claims for hospital treatments. Please ensure that the hospital stamps your form and a hospital official has signed and dated where applicable. Alternatively, please enclose proof of your hospital stay with a MED10 Certificate or Hospital Discharge Note.

Patient's Title: Mr Mrs Ms Miss Other

Patient's full name:

The patient was admitted for the following treatment:

Inpatient ☐ Daycase ☐

Treatment Dates:

Admission Date(s):	Discharge Date(s):	Number of Nights:

Home Leave:

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

From: To:

If the patient attended A&E immediately prior to admission please state date and time of admission:

Date: Time:

Confirmation:

Authorised Signature **(hospital official)**:

Date: Position:

Hospital Stamp:

Hospital Transfers

This section must be completed and signed by the hospital official.
I confirm that the above named patient was transferred from the hospital named above and treated as an inpatient at this hospital.

Admission Date(s):	Discharge Date(s):	Number of Nights:

Home Leave:

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

From: To:

Confirmation:

Authorised Signature **(hospital official)**:

Date: Position:

Hospital Stamp:

Parental Stay

Please complete if a parent / guardian has accompanied a child under 12 during an Inpatient Stay.

Number of Nights: Name of Accompanying Adult:

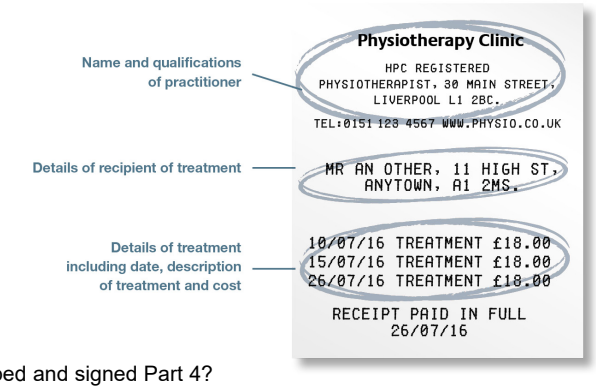
Confirmation: Authorised Signature **(hospital official)**:

Date:

Useful Checklist

Please ensure your receipt(s) is fully paid and details the following:

- ☐ The name and qualifications of the practitioner
- ☐ The full name of the person who received the treatment
- ☐ Details of the treatment including the date it took place and the cost
- ☐ Receipt is not more than 26 weeks old



Before you post your claim form have you:

- ☐ Completed Part 1 and 2?
- ☐ Signed and dated Part 1?
- ☐ Attached the relevant receipt(s)?

If relevant:

- ☐ For birth/adoption of a child claims, have you enclosed the original or certified copy of the full birth certificate or the adoption papers?
- ☐ For hospital claims, has the hospital, or clinic or medical centre completed, stamped and signed Part 4?
- ☐ For Private Medical Insurance claims has Part 3 been completed and attached a statement from the PMI insurer?

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Please ensure you have completed Part 1 and signed the declaration on the front of this form.