

Please write carefully using **BLOCK CAPITALS** in a **BLACK BALLPOINT PEN**. Please ensure that you complete the claim form in full. Failure to do so may result in a delay in processing your claim. Please refer to your policy schedule and table of benefits when claiming to see the benefits and limits applicable to your plan and level of cover.

## Part 1 – Personal Details

Medicash Policy Number		Title: Mr / Mrs / Miss / Ms / Other (Please state)	
Surname		Forename(s)	
Address			
Postcode	Date of Birth	E-mail	
Telephone No.		Mobile No.	

We may from time to time wish to offer you other products and services which we believe may be of interest to you. Should you not wish to receive such communications, please write to The Head of Customer Operations, Medicash, 2-12 Lord Street, Liverpool L2 1TS.

## Payments to your bank account

If you wish for your payments to be **paid directly into the bank**, 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 details have changed.

Sort Code	Account No.	Account Holders Name
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## Please complete this section if you are making a claim for your partner or dependent child

Surname	Forename(s)	Date of Birth
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## 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.
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## Part 2 – Employer's Details – to be completed by the HR or Payroll Department

If your premiums are taken from your wages, salary or pension, please provide the following information:

Company Name		Company Stamp
Company No.	Payroll / Pension / NI No.	
Date of Last Payment		

## Part 3 – Receipted Benefits

Please place a cross in the box of all benefits being claimed. 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.

<input type="checkbox"/> Optical	<input type="checkbox"/> Diagnostic Tests	Amount of Receipt	£	Date	
<input type="checkbox"/> Dental	<input type="checkbox"/> Chiropody	Amount of Receipt	£	Date	
<input type="checkbox"/> Consultancy		Amount of Receipt	£	Date	
<input type="checkbox"/> Other (please state) e.g Physiotherapy	_____	Amount of Receipt	£	Date	
	_____	Amount of Receipt	£	Date	
	_____	Amount of Receipt	£	Date	

If the treatment was given whilst you were abroad, please enter the dates of travel.

Departure Date	Intended Date of Return
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**NB: Some of the benefits we offer are for treatment you receive anywhere in the world during overseas visits that are intended to last no more than 28 days. Please refer to your plan Terms and Conditions to see which benefits are covered abroad.**

**Part 4 – Hospital Inpatient and Daycase Claims – patients details TO BE COMPLETED BY THE WARD CLERK**

This section must be completed by the ward for ALL claims for hospital treatment. 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 as either a MED10 Certificate or Hospital Discharge Note.

Title: Mr / Mrs / Miss / Ms / Other (Please state)

Forename(s)

Surname

Date of Birth

**The patient was admitted for the following treatment**

Inpatient     Accident     Maternity     Daycase

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

Date

Time

**Treatment Dates**

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

**Home Leave**

Has the patient been on home leave? Yes / No

From

To

From

To

**Confirmation**

Authorised Signature

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

**Part 5 – Hospital Transfers**

This section must be completed by the hospital.

**I confirm that the above named patient was transferred from the hospital named in Part 4 and treated as an inpatient at this hospital.**

Admission Date

Discharge Date

Number of Nights

**Home Leave**

Has the patient been on home leave? Yes / No

From

To

From

To

**Confirmation**

Authorised Signature

Date

Position

**Hospital Stamp****Part 6 – Birth of a Child**

Please attach the full birth certificate(s) or certified copy. Alternatively, if you are making a claim for an adopted child please attach the adoption papers including the placement order.

Child 1: Forename(s)

Surname

Date of Birth

Child 2: Forename(s)

Surname

Date of Birth

**Please return this form to:**

**Medicash, Merchants Court, 2-12 Lord Street,  
Liverpool L2 1TS.**

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

Medicash Health Benefits Limited is a company limited by guarantee, registered in England (number 258025) and authorised and regulated by the Financial Services Authority. Medicash is also covered by the Financial Services Compensation Scheme and the Financial Ombudsman Service.

**Checklist:**

- **Have you signed and dated the declaration?**
- **Included your membership number?**
- **Attached the relevant receipts or certificates?**
- **Have the hospital completed Parts 4 and 5 if applicable or attached the confirmation?**
- **Have you had your form approved and stamped by your HR or Payroll Department?**