



Private Medical Insurance (PMI) Excess Claim

Please fill in the details below and include the excess statement from your PMI Provider to support your claim. Please check your benefit table to ensure you are covered for this benefit. For advice on submitting your claim contact 0151 702 0265 or email technicalclaims@medicash.org

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 cheques payable to:

Address:

Postcode:



Hospital Inpatient and Daycase Claims – Patient Details

This section must be completed by the Ward Clerk 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 evidence of your hospital stay with a MED10 certificate or Hospital Discharge Note.



Patient's Title: Mr / Mrs / Ms / Miss / Other: Patient's Forename(s):

Patient's Surname: Date of Birth: / /

The patient was admitted for the following treatment:

Inpatient: Daycase:

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

Date: Time:

Treatment Dates:

Admission Date(s):	Discharge Date(s):	Number of Nights:
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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 has accompanied a child under the age of 12 during an Inpatient Stay.

Number of Nights:

Name of Accompanying Adult:

Hospital Transfer:

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

Admission Date(s):	Discharge Date(s):	Number of Nights:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Leave:

Has the patient been on home leave? Yes No

From: To:

From: To:

Confirmation:

Authorised Signature:

Date: Position:

Hospital Stamp:

MED3364/MAR26