Claim Form

Benenden Health Cash Plan
PO Box 4959
Slough, SL1 0LG
Available from 8:45am - 5:30pm Monday to Friday Customer Helpline: 0800 414 8071
Fax: 0121 454 7725
Email: benenden@bhsf.co.uk

Personal information

Please check the details below and amend where necessary.

Policy Number

Policy Type

Premium

Telephone

Email Address

Notification of claims payments by bank transfer will be sent to this address.

All claims must be submitted within the time stated in your policy terms from the date of the service or treatment provided. Please refer to your policy terms and conditions for full details. Benenden Health Cash Plan is administered by BHSF Limited, this includes the payment of claims. BHSF can be contacted using the details above.

Declaration

The information shown on this form is true and correct. I understand that serious action may result from the submission of a false or misrepresented claim. I confirm that any medical or other practitioner or any other person who has provided healthcare or services for which benefit is being claimed may give BHSF information necessary for the processing of this claim.

Signed ..... **Date** .....

Claimant details

This claim is on behalf of: ☐ myself, the policyholder ☐ my partner/spouse (family schemes) ☐ my dependent child, below age 18 (family schemes)

If the claim is for your partner or child please supply their details below.

Surname ..... **Forename(s)** ..... **Date of Birth** .....

Benefit claimed

Please tick the benefit you are claiming, then insert the value of receipts being claimed for in the box and attach the original receipts to this form.
Please be aware that not all benefits below may be available on your policy. Please note we do not accept credit/debit card receipts.

Receipt amount being claimed

☐ **Acupuncture**	£
☐ **Chiropody**	£
☐ **Chiropractic**	£
☐ **Dental**	£
☐ **Hearing aids**	£
☐ **Homeopathy**	£
☐ **NHS prescriptions**	£

☐ **Hospital day-case surgery** - Hospital to complete section A overleaf*

☐ **Hospital in-patient** - Hospital to complete section B overleaf*

* Any charges payable in respect of the completion of the medical details by the hospital(s) will be the responsibility of the claimant.

☐ **New Child/Adoption Benefit** - please supply a copy of the baby's birth certificate or a copy of the legal adoption papers.

☐ **Optical** - if claiming for contact lenses please provide a breakdown of costs.	£
☐ **Osteopathy**	£
☐ **Physiotherapy**	£
☐ **Reflexology**	£

Settlement

Payment is made directly into your bank account, using the following details. If they have changed, please amend where applicable. Please note not all Building Societies accept BACS payments.

Sort Code | **Account Holder's Name**

Account Number | **Building Society Roll No or Name of Bank**

OFFICE USE ONLY

Hospital Claims

The following sections are to be completed by a member of the hospital personnel and the signatory only. Completion by any other person may delay payment of the claim.

Certification

I certify that:

Patient's name ..... attended the hospital as detailed below.

Do they reside at the address overleaf? ☐ Yes ☐ No

Patient's Hospital Number .....

A Day-case surgery - must be completed by the hospital personnel who signs section C.

I certify that the above named person attended this hospital on / / for day-case surgery.

Surgery was performed under: ☐ Sedation ☐ General/local anaesthetic

Was an overnight stay involved? ☐ Yes ☐ No
Please complete section B if an overnight stay was involved.

Was the surgery scheduled? ☐ Yes ☐ No

Was the surgery a scope procedure - e.g. Endoscopy? ☐ Yes ☐ No

Was the procedure an injection administered for the relief and/or control of pain only? ☐ Yes ☐ No

B Hospital in-patient - must be completed by the hospital personnel who signs section C.

I certify that the above-named person was an in-patient of this hospital during the following period(s).

Date of admission / / Date of discharge / /

Date of re-admission (if applicable) / / Date of discharge (if applicable) / /

Home Leave? Yes / No (delete as applicable) Date(s) of home leave

Category of stay (please tick)

☐ Acute Illness ☐ Accident ☐ Geriatric/Elderly Rehab ☐ Psychiatric ☐ Maternity ☐ Maternity (confinement)

If maternity-related please insert the expected date of confinement. / /

C Hospital official use only

Name..... Status .....

Signed..... Date .....

Contact telephone number.....

Hospital's Official Stamp

For Dental Trauma or Personal Accident claims, please telephone 0800 414 8071.