

Westfield Health

Westfield House 87 Division Street Sheffield S1 1HT
 Customer Helpline: 0114 250 2000
 Available from 8am-6pm Monday to Friday
 Textphone: 0114 250 2020 Fax: 0114 272 4950
 E-mail: enquiries@westfieldhealth.com
 website: westfieldhealth.com



Verify <input type="checkbox"/>	Optical <input type="checkbox"/>	Dental <input type="checkbox"/>	for office use only
Notes			
D/C <input type="checkbox"/>			
CHQ <input type="checkbox"/>			

CLAIM FORM - Westfield Flex Health Cash Plan

Please write carefully in BLACK INK within the boxes in BLOCK CAPITALS
 Please ensure you complete the claim form in full.
 Failure to do so may result in a delay in processing your claim.

Part 1		Please circle		
Westfield Account No.	<input type="text"/>	Mr/Mrs/	Date of Birth	DAY MONTH YEAR
Surname	<input type="text"/>	Miss/Ms/	<input type="text"/>	<input type="text"/>
First Name	<input type="text"/>	Dr/	Please place a cross in this box if this is a change of address <input type="checkbox"/>	
House Number/Name	<input type="text"/>	Other _____		
Street	<input type="text"/>			
Town	<input type="text"/>			
Contact Tel No.	<input type="text"/>	Postcode	<input type="text"/>	
Mobile No.	<input type="text"/>			
If you wish your payment to be paid directly into the bank, then please enter your account details. If you have already provided these details then there is no need to fill them in again unless your account details have altered.				
Account No.		<input type="text"/>	Sort Code	<input type="text"/>

Please fill in this section if the claim is for your partner or dependent child.
 Dependent child - Optical, Dental, In-patient, Day Surgery and Consultation.

Dependant's Surname	<input type="text"/>	Date of Birth	DAY MONTH YEAR
Dependant's First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Is the dependant resident with the policyholder?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Declaration
 The information shown in this form is true and complete. I will give you any proof you have asked for. Any medical practitioner or other person concerned with providing health care may give you any information relevant to this claim that you ask for.

Policyholder's Signature **Date** DAY MONTH YEAR

Part 2 If your premiums are taken from your wages, salary or pension, please give us the following information.

Name of company
 Department Payroll/Pension number

Part 3 Please place a cross in the box showing the benefit you are claiming.

For the benefits shown below, please enclose the relevant original receipted account. For Optical, Dental, Day Surgery, In-patient or Consultation benefits, where the treatment is for a dependant, give their details in Part 1. (We will check the information you give us). Your receipt should clearly show the name and address of your practitioner.

Optical (you)	<input type="checkbox"/>	£ <input type="text"/>	Date of the receipt	DAY MONTH YEAR
Optical (dependent child)	<input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>	<input type="text"/>
Please enclose the receipt and say how much you paid				
Dental (you)	<input type="checkbox"/>	£ <input type="text"/>	Date of the receipt	DAY MONTH YEAR
Dental (dependent child)	<input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>	<input type="text"/>
Please enclose the receipt and say how much you paid				
Maternity	<input type="checkbox"/>	Please send us your child's full birth certificate, which will be returned once the claim is processed. We must receive your child's birth certificate within 13 weeks of the date of birth.		
Health Screening	<input type="checkbox"/>	£ <input type="text"/>	Date of the receipt	DAY MONTH YEAR
Please enclose the receipt and say how much you paid				
For all claims in this section your receipt should clearly show the practitioner's name and qualifications.				
Physiotherapy	<input type="checkbox"/>	Acupuncture	<input type="checkbox"/>	Osteopathy
Consultation	<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	Homeopathy
				You <u>must</u> name the Doctor (below) who recommended the treatment (not required for chiropody)
Please enclose the receipt and say how much you paid				Date of the receipt
£ <input type="text"/>				DAY MONTH YEAR <input type="text"/>

Part 4 In-patient / Day Surgery Please ensure that all relevant information is provided to avoid delay in progressing your claim

The hospital, registered treatment centre or hospice must fill in this section and use their official stamp.

Official stamp of hospital, registered treatment centre or hospice

Hospital Number

This is to certify that (Patient's name)
of
..... (address)

Was admitted as an In-patient

Day the patient was admitted [] [] [] Date DAY MONTH YEAR
(Mon, Tues, Wed, Thurs, Fri, Sat, Sun)
Day the patient was discharged [] [] [] Date DAY MONTH YEAR

Please detail below any nights that the patient was **not** an In-patient during the period mentioned above.

Signature

Designation Date DAY MONTH YEAR

Or was admitted as a Day Case Patient

Date DAY MONTH YEAR

Please state medical procedure [] Please refer to Policyholder's consent declaration part 1

Was allocated a bed or a similar facility that the treatment provider classes as a bed (usually for a period of supervised recovery) Yes [] No []

Underwent a Surgical Procedure ** using theatre facilities Yes [] No []

(*A procedure requiring the use of local, regional or general anaesthetic, for the purpose of treating disease, injury or abnormality by operating directly on or removing the affected part, or removing a foreign body. Please note does not include tests or investigations e.g. biopsies and endoscopies carried out for investigative purposes only.)

If the procedure was a test or investigation was treatment carried out at the same time Yes [] No []

If yes please give details of the treatment carried out

Signature

Designation Date DAY MONTH YEAR

4.1 You must fill in this section

Did you stay in hospital for maternity reasons? Yes [] No []
(we will only pay In-patient benefit from the 11th night if your stay is maternity related)

Did you stay in hospital because you had an accident? Yes [] No []

What date did your accident happen? DAY MONTH YEAR (Please send us full written details of the accident)