

# 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
			CHQ

## CLAIM FORM

Please write carefully in BLACK INK within the boxes in BLOCK CAPITALS  
 We must receive your claim within 13 weeks of the date of each receipt.

### Part 1

Westfield Account No.

Surname

First Name

House Number/Name

Street

Town  Postcode

Contact Tel No.

Email address

Date of Birth DAY MONTH YEAR

Please place a cross in this box if this is a change of address

Please place a cross in this box to receive payment advice via email

If you wish your payment to be paid directly into the bank, then please enter **your** account details. We can only credit an account that is held in your name. If you have already provided these details then there is no need to fill them in again unless your account details have altered.

Marketing Preferences  Account No.  Sort Code

We may occasionally use your contact information to contact you by post, email, text or phone with marketing offers and details of our other products and services. We may also share all contact details with other selected organisations who may contact you by post or phone about other products and services. To opt out please contact us at the above address. If you are also happy to receive emails/texts from these other selected organisations please contact us at the above address.

### Please fill in this section if the claim is for your partner or dependent child.

Dependent child - Optical, Dental, In-patient, Recuperation, Day Surgery and Consultation. Partner - Consultation and Home Care.

Dependant's Surname

Dependant's First Name

Date of Birth DAY MONTH YEAR

Is the dependant resident with the policyholder? Yes  No

### Declaration and Signature

Westfield Contributory Health Scheme Ltd. will only pay a proportionate share of any claim if you have other health insurance in place. If you have another insurance policy that may cover this claim, please tick to say whether or not you intend to claim on that insurance policy. If you tick Yes, please provide full details of the other insurance provider and the amount being claimed. Yes  No

#### Fraudulent Claims / Fair Processing Notice

In the interest of all of our customers, detection of fraudulent claims may result in legal action being taken, immediate cancellation of your policy and all benefit rights. We may also seek to recover any monies paid to you that were not due under the Terms and Conditions of this policy. For audit purposes we will carry out checks on the information you and practitioners provide to us, this may include Sensitive Personal Data such as data relating to health and medical conditions. For the detection and prevention of fraud we may share this information with other insurance providers; selected third parties; police and other enforcement agencies; and the employer (if they are paying some or all of the premium for your cover) where we have a reasonable belief that the claims activity is in serious breach of our terms and conditions and/ or may be fraudulent.

I declare that the information shown on this form and any accompanying documentation is true and complete. I will give you any proof or further information you ask for. I authorise any medical practitioner or other person(s) concerned with providing health care to give you any information relevant to this claim and or my policy. Where I have provided information about another person I have obtained their consent to do so.

Policyholder's Signature  Date DAY MONTH YEAR

### Part 2 Please enclose the relevant original receipted account clearly showing the name, address and qualifications of the practitioner. We will not accept visa/debit card receipts or photocopies.

**PLEASE NOTE YOU CANNOT CLAIM FOR YOUR PARTNER (with the exception of consultation and home care)**

Optical (you)  £  .  Date of the receipt DAY MONTH YEAR

Optical (dependent child)  £  .  Date of the receipt DAY MONTH YEAR

Please enclose the receipt and say how much you paid

Dental (you)  £  .  Date of the receipt DAY MONTH YEAR

Dental (dependent child)  £  .  Date of the receipt DAY MONTH YEAR

Please enclose the receipt and say how much you paid

Dental Trauma (you)  £  .  Date of the receipt DAY MONTH YEAR

Dental Trauma (dependent child)  £  .  Date of the receipt DAY MONTH YEAR

Please enclose a receipt which specifically confirms that treatment is a consequence of an accidental injury and provide written details of the accident.

Full Dentures  The dentist's receipted account should confirm that full dentures have been supplied. DAY MONTH YEAR

Please enclose the receipt and say how much you paid £  .  Date of the receipt DAY MONTH YEAR

For all claims in this section your receipt should clearly show the practitioner's name and qualifications.

Physiotherapy  Acupuncture  Osteopathy  Please name the condition you are receiving treatment for.

Chiropractic  Chiropody  Homeopathy

Please enclose the receipt and say how much you paid £  .  Date of the receipt DAY MONTH YEAR

**Part 2 continued**

**You must name the Doctor who recommended the consultation**

Consultation	<input type="checkbox"/>		
Surgical Appliance	<input type="checkbox"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	Date of the receipt DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/>
Please enclose the receipt and say how much you paid			
Appliance .....	Prescribed by .....	Designation .....	
<i>(Please state type of appliance)</i>	<i>(Full name of practitioner)</i>	<i>(Type of practitioner for example Chiroprapist)</i>	
Home Care	<input type="checkbox"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	Date of the receipt DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/>
Please enclose the receipt with supporting documentation and say how much you paid			
Health Screening	<input type="checkbox"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	Date of the receipt DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/>
Please enclose the receipt and say how much you paid <i>This only applies to the two highest levels of cover</i>			
Maternity/Paternity/Adoption	<input type="checkbox"/>	<i>Please send us your child's original 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.</i>	

**Part 3 In-patient / Day Surgery / Recuperation** 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** We must receive your claim within 13 weeks of the discharge date.

Day the patient was admitted	<input type="text"/>	Date	DAY <input type="text"/> <input type="text"/>	MONTH <input type="text"/> <input type="text"/>	YEAR <input type="text"/> <input type="text"/>
	<small>(Mon, Tues, Wed, Thurs, Fri, Sat, Sun)</small>				
Day the patient was discharged	<input type="text"/>	Date	DAY <input type="text"/> <input type="text"/>	MONTH <input type="text"/> <input type="text"/>	YEAR <input type="text"/> <input type="text"/>

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

Total number of nights spent in Hospital

Signature/Designation .....

Date DAY  MONTH  YEAR

**Or was admitted as a Day Case Patient**

Date DAY  MONTH  YEAR  We must receive your claim within 13 weeks of this date.

Please state medical procedure including any treatment e.g. chondroplasty, as we do not cover tests or investigations e.g. biopsies or endoscopies carried out for investigative purposes only.

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.

Signature .....

Designation .....

Date DAY  MONTH  YEAR

**3.1 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)

**We will only pay benefit under the General Terms and Conditions and Benefit Rules shown in our current leaflet. We must receive claims within 13 weeks of the date of each receipt for which you are claiming benefit. If any documentation submitted is found to be deliberately untrue, this may lead to the termination of your policy.**