Westfield Health

Westfield Health

Westfield Health, PO Box 340, Sheffield, S98 1XB
Customer Helpline: 0114 250 2000
Available from **8:30am - 5:30pm** Monday to Friday
E-mail: enquiries@westfieldhealth.com
website: westfieldhealth.com

Verify		Optical	Dental	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 payment.

Part 1

Westfield Account No.

Date of Birth DAY MONTH YEAR

Surname

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

First Name

House Number/Name

Street

Town

Postcode

Contact Tel No.

Email address

Claim payment confirmation will be sent by email.
Your payment will be paid directly into your bank, 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. Sort Code

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

Dependent child - Optical, Dental, Dental Accident, Hospital Benefit and Consultation. **Partner** - Consultation

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

Fradulent 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 information 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. Westfield Health take your privacy very seriously, if you would like to know more about how we process your data, please see our detailed Privacy Notice, which is available on our website.
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 X ..... 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)

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

Dental Accident *(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

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

Physiotherapy Acupuncture Osteopathy

Chiropractic Chiropody Homeopathy

Please name the condition you are receiving treatment for.

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

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

Appliance ..... Prescribed by ..... Designation .....
(Please state type of appliance) *(Full name of practitioner)* *(Type of practitioner for example Chiropodist)*

Health Screening
Please enclose the receipt and say how much you paid £ . Date of receipt DAY MONTH YEAR
This only applies to the two highest levels of cover

Maternity/Paternity/Adoption
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.

Part 3 Hospital Benefit. 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 official stamp.

Official stamp of hospital, registered treatment centre or hospice.

Hospital Number

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

Was admitted as an inpatient. We must receive your claim within 13 weeks of the discharge date.

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

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.

.....

Total number of nights spent in hospital

Or was admitted as a Day 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 investigation e.g. biopsies or endoscopies carried out for investigation 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

NHS Prescription Charges

Please confirm you are not exempt from paying NHS prescription charges

Total number of charges claimed

Please enclose the relevant original receipt clearly showing your name and the name and address of the dispensing practitioner.
We will not accept debit/credit card receipts or photocopies.

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

Official Stamp of Pharmacy

If you do not have a receipt confirming your name please ask the pharmacy to stamp here and complete the section below

This is to certify that.....(Patient's name)
has paid the above charges towards the cost of their own prescription items.

Signature .....

Designation ..... Date of receipt DAY MONTH YEAR

If you have purchased a Prescription Pre-payment Certificate (PPC) you must provide us with evidence of this e.g: a copy of the PPC11 letter issued by the NHS Business Services Authority when they issue your PPC.

Is the PPC valid for 3 months 12 months Date of receipt 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 was 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 this accident)**

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