## **Benefit claim form**

Subject to our current Benefit and General Conditions.

## Please return to:

WHA Healthcare, WHA House, Greenwood Close, Cardiff Gate Business Park, Cardiff, CF23 8RD Tel: 029 2048 5461



Separate claim forms are required for each claim. No more than one claim per form please.		
Name, address and postcode of subscriber	Date of birth	
	Marital status (please tick one)	
	Married Widowed	
	Single Divorced	
	Legally separated Civil partnership	
Membership number	Daytime telephone number	
Please indicate who you are claiming for	Data Protection	
A Subscriber	We will use the information you provide to us on	
B Subscriber's spouse Name	this form for the purposes of administering your policy and processing any claims. For further	
C Additional member Name		
Relationship to subscriber	information, our legal basis for doing so and your	
Marital status	please see our Privacy Notice at whahealthcare.	
Date of birth	co.uk/privacy-policy.asp	
Date of birth		
DECLARATION		
By submitting this form, I confirm the accuracy of information provided and fee payments made by either myself or the patient, without eligibility for reimbursement elsewhere and acknowledge that any fraudulent attempts will lead to legal action. I authorise WHA Healthcare to process health data for claim assessment, including contacting practitioners for eligibility verification.		
Signature		
Date		
Section 1 Hospital inpatient		
To be certified on discharge from hospital or when the patient has been in hospital for 42 days		
Patient's name:		
Forename(s) Surname	Date of birth	
Medical classification Accident Emergency C	Other (please state)	
First inpatient admission		
Name of hospital (official stamp)	Admitted DD-MM-YY	
D	Discharged DDD-MMD-YYY or still in hospital	
s	signature and position of hospital officer	
Second inpatient admission		
Name of hospital (official stamp)	Admitted DD-MM-YY	
D	Discharged DDD-MMD-YYY or still in hospital	
	signature and position of hospital officer	

Section 2 Hospital Outpatient	Section 7 Alternative Therapies
Name of hospital (official stamp)	For Acupuncture, Alexander Technique, Bowen Therapy and Sports Therapy/Massage. To be completed by the Practitioner. The Practitioner's receipt must be submitted.  Practitioner is qualified to provide the following treatment
Attendance dates (minimum of three)  First DD-MM-YY  Second DD-MM-YY  Third DD-MM-YY	Patient's name  Description of condition treated  Dates of treatment from  Practitioner's qualification/registration  Number of treatments  Cost per treatment £  The PRACTITIONER'S CERTIFICATION section must be completed
Date	and stamped.
Section 3 Personal Accident	Section 8 Physiotherapy, Osteopathy, Chiropractic & Chiropody/Podiatry
Personal accident benefit is not applicable to Personal 7 and Partners 14 schemes.	To be completed by the Practitioner. The Practitioner's receipt must be submitted.
Please send me a Personal Accident claim form, if eligible (please tick box)  Details of injury suffered	Practitioner's profession (please tick as appropriate)  Physiotherapist Osteopath  Chiropractor Chiropodist/Podiatrist  HCPC/GOC/GCC Number
Section 4 Counselling	Patient's name
To be completed by the Practitioner. The Practitioner's receipt must be submitted.  Name of patient  Description of condition  Dates of appointments from	Description of condition treated
The PRACTITIONER'S CERTIFICATION section must be completed and stamped.	Section 9 Specialist Consultation
Section 5 Optical	To be completed by the Consultant. The Consultant's receipt must be submitted.
To be completed by the Optician. The Optician's receipt must be submitted.  Name of patient	Name of patient  Condition which necessitated the consultation
Details/description of lenses	The PRACTITIONER'S CERTIFICATION section must be completed and stamped.
Date of supplyPrescription/test date	PRACTITIONER'S CERTIFICATION  Full name
Value of vouchers towards cost £ (if any)  The PRACTITIONER'S CERTIFICATION section must be completed and stamped.	Qualifications Signature
Section 6 Dental	Amount paid £ Amount paid in words (pounds only)
To be completed by the Dentist. The Dentist's receipt must be submitted.  Name of patient  Details/description of treatment  Dates of treatment from	pounds  Practitioner's official stamp/business card
The PRACTITIONER'S CERTIFICATION section must be completed	А

and stamped.