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

WHA Healthcare

Part 1 Must be completed and signed by the person who actually pays the contributions by payroll deduction or direct to WHA Healthcare.
Part 2 Must be completed and signed by an authorised person.
IN ALL CASES The appropriate Benefit Section must be completed and certified.

Part 1 Details of Contributor

Title .....
Forename(s) .....
Surname .....
Address .....
..... Postcode
Email .....
Mobile/Tel .....
Policy No. .....

Date of Birth ☐☐-☐☐-☐☐

Marital Status (please tick one)

☐ Married	☐ Widowed
☐ Single	☐ Divorced
☐ Common-law partners	☐ Legally separated

Employer

Daytime telephone number

Please indicate who you are claiming benefit for . . .

A Contributor	☐		
B Contributor's spouse	☐	Name	Age
C Child under 18	☐	Name	Age
D Additional member	☐	Name	Age

Relationship to contributor

Marital status

Date of birth ☐☐-☐☐-☐☐

DATA PROTECTION

We will use the information you provide to us on this form for the purposes of administering your policy and processing any claims. For further information as to how we will use your personal information, our legal basis for doing so and your rights in relation to your personal information please see our Privacy Notice at whahealthcare. co.uk/privacy-policy.asp

DECLARATION - Please ensure this is signed before sending back to us

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:** .....

SEPARATE CLAIM FORMS ARE REQUIRED FOR EACH CLAIM. NO MORE THAN ONE CLAIM PER FORM PLEASE.

Part 2 Certification of membership

Certification of membership should be by an authorised person at the place of employment. Direct subscribers should ignore this section.

Employer name

Date contributor joined

Date contributions paid up to

EMPLOYER'S CERTIFICATION

I certify that the above named is a regular contributor at the rate of **£** . per week / mth / qtr (circle one)

Signature

Position held

Date

Sections 1&2 Hospital inpatient & outpatient (excluding maternity - see section 3)

To be certified on discharge/completion of a 90 day stay or, for outpatient, of four attendances in a continuous period of six months

Patient's name First Last DOB ☐☐-☐☐-☐☐

Medical classification ☐ Accident ☐ Emergency ☐ Psychiatric ☐ Geriatric ☐ Ante/postnatal ☐ Other

1st **INPATIENT** hospitalisation Name of hospital (official stamp)

Admitted ☐☐-☐☐-☐☐ Discharged ☐☐-☐☐-☐☐ or still in hospital

Signature and position of hospital officer

Date ☐☐-☐☐-☐☐

2nd **INPATIENT** hospitalisation Name of hospital (official stamp)

Admitted ☐☐-☐☐-☐☐ Discharged ☐☐-☐☐-☐☐ or still in hospital

Signature and position of hospital officer

Date ☐☐-☐☐-☐☐

OUTPATIENT attendances Name of hospital (official stamp)

Attendance dates (minimum of four)

1st ☐☐-☐☐-☐☐
2nd ☐☐-☐☐-☐☐
3rd ☐☐-☐☐-☐☐
4th ☐☐-☐☐-☐☐

Signature and position of hospital officer

Date ☐☐-☐☐-☐☐

Please ensure when submitting your claim, you attach an identifiable receipt which must include your full name.

Section 3 Maternity benefit (hospital or home birth)

To be completed by doctor, midwife or hospital officer.

Name of mother

Where confined

Date of confinement

Male/female child

If twins or more, state number of children here and enclose birth certificates

Period in hospital (if applicable) Admitted

Discharged

Name of hospital (official stamp)

I certify that a confinement took place after not less than 28 weeks of pregnancy. Signature of doctor, midwife or hospital officer.

Signature

Status/qualification

Date

WHA may request that birth certificate/s be submitted

Section 4 Convalescent home

If you want WHA to arrange your admission to a convalescent home, your General Practitioner must complete the section below.

Doctor's recommendation: I recommend (insert patient's name)

Who is recovering from (insert nature of condition)

for a stay in a convalescent home, if considered eligible.

Nature of any disability

Signed

Date

Qualifications

Section 5 Optical (spectacles, lenses and contact lenses)

To be completed by the optician. The patient must attach a receipt of payment to this claim form.

Name of patient

Details/description of lenses

Date of supply

Prescription/test date

Value of NHS vouchers £ . (if any)

The optician must certify this claim by stamping and completing the PRACTITIONER'S CERTIFICATION box opposite.

Section 6 Dental (including dentures)

To be completed by the dentist. The patient must attach a receipt of payment to this claim form.

Name of patient

Details / description of treatment

Date of treatment from to

The dentist must certify this claim by stamping and completing the PRACTITIONER'S CERTIFICATION box below.

Section 7 Personal accident benefit

Personal accident benefit is not applicable to Personal 145, Partner 145 and Partner 290.

Please send me an application form for personal accident benefit (tick) ☐

Details of injury suffered

Section 8 Complementary treatments

For physiotherapy, osteopathy, chiropractic, acupuncture and chiropody benefit claims. To be completed by the qualified practitioner. The patient must attach a receipt of payment. SEE SECTION 2 FOR NHS PHYSIOTHERAPY CLAIMS.

I certify that (patient's name)

suffering from

has received (tick one) ☐ Physiotherapy ☐ Chiropractic

☐ Osteopathy ☐ Acupuncture ☐ Chiropody

date of treatment from to

Number of treatments ☐ Cost per treatment £

The practitioner must certify this claim by stamping and completing the PRACTITIONER'S CERTIFICATION box below.

Section 9 Specialist consultation

To be completed by the consultant (receipt to be attached). SEE SECTION 2 FOR NHS CONSULTATION CLAIMS.

I certify that (patient's name)

has attended for a consultation in respect of (nature of condition):

The practitioner must certify this claim by stamping and completing the PRACTITIONER'S CERTIFICATION box below.

PRACTITIONER'S CERTIFICATION

Full name

Signature

Qualifications

Date

Amount Paid £ .

Amount paid in words (pounds only)

pounds

Official stamp including name and address