medicash
a positive approach to health

- Please include your Medicash Policy Number.
- Please sign this claim form or your form will be returned for a signature.
- Any errors or omissions may result in a delay in the processing of your claim
- Please write carefully using BLOCK CAPITALS in BLACK INK and do not use staples.

Once complete, please return this form to:
Medicash, One Derby Square, Liverpool L2 1AB

If you have a query please contact us on 0151 702 0265 or email claims@medicash.org. Telephone lines are open Monday to Thursday 8.45am to 5pm and Friday 8.45am to 4pm (excluding public holidays).

Policyholder Details – If your personal details have changed please contact us prior to making a claim.

Policy Number:

Address:

Title: Mr / Mrs / Ms / Miss / Other:

Postcode:

Surname:

Daytime Tel. No.

Forename(s):

Date of Birth: / /

You can now submit claims electronically, register for paperless communications and have your claims paid directly into your bank account using the My Medicash App available free on the App Store and Google Play.

Alternatively, to have claims paid directly into your bank account, change your bank account details or to update your Marketing and Privacy preferences call 0151 702 0265 or visit www.medicash.org

Declaration:
I hereby declare that the information given by me in relation to this claim is complete and accurate and that I have the explicit permission of all individuals involved to supply this information. I also give my permission to Medicash to make any reasonable enquiries that it deems necessary to validate this claim.

Signature: X

Date: / /

NB: To protect all members, Medicash will take action against anyone who makes a dishonest or false claim. Such actions could include, but are not limited to, refusal to accept liability to pay a claim, termination of your policy or legal action. To detect and prevent fraud or improper claims we may check your details with fraud protection agencies. If we reasonably suspect fraud, we will record and investigate this, including working with other organisations and other insurers to pool applications or claims which are believed to be fraudulent and may contact the police.

If you are claiming for a receipted treatment benefit or a prescription please complete the box below.

Receipted Benefits

Please place a cross (x) in the boxes below to identify the person claiming and the benefit being claimed. Please complete a separate line for each receipt, up to a maximum of 4 receipts per claim form. You can use this form to claim more than one type of benefit. Please ensure that you enclose all the relevant, original receipts with this claim form. Details of your benefit allowances are noted on your policy benefit table.

Who is the receipt for?			What are you claiming for?					What is the total amount of the receipt?	What is the date of your receipt?
Policyholder	Partner	Child	Optical	Dental	Chiropody	Physio	Other	£ .	D D / M M / Y Y Y Y
☐	☐	☐	☐	☐	☐	☐	☐	£ .	/ /
☐	☐	☐	☐	☐	☐	☐	☐	£ .	/ /
☐	☐	☐	☐	☐	☐	☐	☐	£ .	/ /
☐	☐	☐	☐	☐	☐	☐	☐	£ .	/ /

PMI Excess Claim

Please place a cross in the relevant box and complete the PMI section on the next page.

Claimant:
Policyholder ☐
Partner ☐
Child ☐

Treatment date: / /

Hospital Claim

Please place a cross in the relevant box and complete the Hospital section on the next page.

Claimant:
Policyholder ☐
Partner ☐
Child ☐

Treatment received:
Inpatient ☐ Daycase ☐

Birth/Adoption of a Child

Please place a cross in the box and attach the full original birth certificate(s). If you are making a claim for an adopted child please attach the adoption papers including the placement order.
☐

Private Medical Insurance (PMI) Excess Claim

Please fill in the details below and include the excess statement from your PMI Provider to support your claim. Please check your benefit table to ensure you are covered for this benefit. For advice on submitting your claim contact 0151 702 0265 or email technicalclaims@medicash.org

Have you paid the practitioner? Yes ☐ No ☐ Make payment for this claim to: Policyholder ☐ Practitioner ☐

If this is to be paid directly to your practitioner please enter their details below:

Make cheques payable to:

Address:

Postcode:

Hospital Inpatient and Daycase Claims – Patient Details

TO BE COMPLETED BY THE WARD CLERK

This section must be completed by the Ward Clerk for ALL claims for hospital treatment. Please ensure that the hospital stamps your form and a hospital official has signed and dated where applicable. Alternatively, please enclose evidence of your hospital stay with a MED10 certificate or Hospital Discharge Note.

Patient's Title: Mr / Mrs / Ms / Miss / Other:

Patient's Forename(s):

Patient's Surname:

Date of Birth: / /

The patient was admitted for the following treatment:

Inpatient: ☐ Daycase: ☐

If the patient attended A&E immediately prior to admission please state the date and time of admission:

Date: Time:

Treatment Dates:

Admission Date(s):	Discharge Date(s):	Number of Nights:

Home Leave:

Has the patient been on home leave? Yes ☐ No ☐

From: To:

From: To:

Confirmation:

Authorised Signature:
X

Date: Position:

Hospital Stamp:

Parental Stay:

Please complete if a parent has accompanied a child under the age of12 during an Inpatient Stay.

Number of Nights:

Name of Accompanying Adult:

Hospital Transfer:

This section must be completed by the hospital.
I confirm that the above named patient was transferred from the named hospital and treated as an inpatient at this hospital.

Admission Date(s):	Discharge Date(s):	Number of Nights:

Home Leave:

Has the patient been on home leave? Yes ☐ No ☐

From: To:

From: To:

Confirmation:

Authorised Signature:
X

Date: Position:

Hospital Stamp:

MED2653/JAN21