

# Cash plan claim form

You can use this form to make a claim on your Sovereign Health Care cash plan. Please refer to your policy terms and conditions to check which benefits you are eligible to claim for. If you have any questions please contact the Sovereign Health Care claims team on **01274 841160**. Lines are open Monday to Thursday 9am to 5pm and Friday 9am to 4pm.



## Section A – about you

Please complete the fields below:

Policy number: SP \_\_\_\_\_

Title \_\_\_\_\_ Full name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Postcode \_\_\_\_\_

Please provide your contact details below:

Telephone \_\_\_\_\_

Mobile \_\_\_\_\_

Email \_\_\_\_\_

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## Section B – about your claim

**Who are you claiming for?** Please tick as appropriate and provide the additional information requested.

Myself  My date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ My dependent child  Child's date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent child's name: Master/Miss\* Full name \_\_\_\_\_

\*Delete as appropriate

**Which benefit(s) are you claiming for?** Please tick as appropriate. You can claim for multiple items on the same form but you must claim within twelve months of the date any treatment was received or the completion date of any hospital treatment.

Dental <input type="checkbox"/>	Physiotherapy/Osteopathy/Chiropractic <input type="checkbox"/>	Home care <input type="checkbox"/>
Optical <input type="checkbox"/>	Acupuncture/Homeopathy/Reflexology <input type="checkbox"/>	Hearing aids <input type="checkbox"/>
Prescription charges <input type="checkbox"/>	Birth/adoption of a child <input type="checkbox"/> <small>(Please enclose a photocopy of the birth certificate/adoption papers)</small>	Specialist medical aids <input type="checkbox"/> <small>(Formerly 'surgical appliances')</small>
Chiropody/Podiatry <input type="checkbox"/>	Hospital consultant fees and diagnostic tests <input type="checkbox"/>	Health screening <input type="checkbox"/>
Hospital in-patient <input type="checkbox"/> <small>(For hospital in-patient and day case admission claims please also complete section D overleaf)</small>	Hospital day case admission <input type="checkbox"/>	

**Please add up the total receipt(s) values and enter the amount here: £** \_\_\_\_\_

Please enclose all original, named receipts with your completed claim form. Each receipt must be in the name of one person only. Receipts for dependent children must be in the child's name. To make a valid claim for prescription charges, you must obtain an original, named receipt from a registered pharmacist on the day you pay for your prescription.

**Would you like to have your claims paid into a bank account?**

Simply complete this section to have your claims paid directly into a bank account by direct credit. If you have previously provided these details then you do not need to give them again, unless your bank details have changed.

Account holder's name \_\_\_\_\_ Name of bank \_\_\_\_\_

Sort code  -  -  Account number

I authorise Sovereign Health Care to pay my claims into this bank account until further notice.

## Section C – declaration

I confirm the amount(s) shown on the attached receipt(s) are only for those charges incurred by myself or on behalf of my dependent child. I confirm my dependent child is under the age of 18 and resides with me at the address above. I also confirm my claim is only for treatments covered as detailed in my policy terms and conditions.

Occasionally we may request a medical report from you, your GP or health care provider/practitioner to verify a claim. By signing this declaration you consent to us doing this. If we make such a request, checks will be carried out in accordance with the Access to Medical Records Act 1988, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Data Protection Act 1998. If we do seek additional information and/or if your GP or health care provider/practitioner makes a charge for completing your claim form, we will not pay for any amount you may be charged by them for doing this. These charges will be your responsibility. We are members of the Health Insurance Counter Fraud Group (HICFG) and will share information about suspected fraudulent activity with HICFG.

**Policyholder signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

Please turn over...

## Section D – Hospital claims (in-patient and day case admission)

This section of the form must be completed, stamped and signed by the hospital where you received treatment.  
Please enter the patient's full name and date of birth:

Patient's full name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Admission details:**  Day case  In-patient

Patient's hospital registration number \_\_\_\_\_ Ward number \_\_\_\_\_ General  Maternity

**Admission duration:**

Day case admitted on \_\_\_\_/\_\_\_\_/\_\_\_\_

As an in-patient admitted on \_\_\_\_/\_\_\_\_/\_\_\_\_ and discharged on \_\_\_\_/\_\_\_\_/\_\_\_\_ Number of nights \_\_\_\_\_

Benefit is not payable for periods when the patient is allowed out of hospital for any reason (i.e. to work or leave of absence).  
Please provide the dates of any leave of absence below:

Absence 1 from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ Absence 2 from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**I certify that the above patient was admitted to this hospital, on these date(s), for the reason detailed below.**

**Nature of treatment/procedure**

**Hospital stamp**

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Useful checklist

**Please ensure your receipt(s) details the following:**

- The name and qualifications of the practitioner
- The full name of the person who received the treatment
- Details of the treatment including the date it took place and the cost

**Before you post your claim form have you:**

- Completed sections A and B?
- Signed and dated section C?
- Attached relevant named receipt(s)?

**If relevant:**

- For birth/adoption claims, have you enclosed a photocopy of the full birth certificate/adoption papers?
- For hospital claims, has the hospital completed, stamped and signed section D?

**Next steps:** Please return your completed claim form and original, named receipt(s) or documents in an envelope to Sovereign Health Care, Royal Standard House, 26 Manningham Lane, Bradford BD1 3DN. Please remember to affix the appropriate postage stamps to the envelope.

### Sample of receipt

<p><b>Chiropody Clinic</b></p> <p>123 Anyroad Any Town BD1 1BB</p> <p>Tel: 01274 000000</p> <p>Mr A.N Other Dip.Phys M.C.S.P.S.R.P HPC Registration Number PH12345</p> <p>Mrs A Sample, 1 Sample Road Halifax, HX1 1HS</p> <p>01/06/2012 Treatment £45.00 07/06/2012 Treatment £45.00</p> <p>Total received with thanks £90.00 08/06/2012</p>
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