Cash plan claim form

You can use this form to make a claim on your 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 customer support team on **01274 841130**. Lines are open Monday to Thursday from 9am to 5pm, and Fridays from 9am to 4pm, or you can email help@sovereignhealthcare.co.uk.

Section A - about you

Please fill in the fields below:

Policy number: ____________________

Title ______ Full name ____________________

Address ____________________

____

____________________ Postcode ____________

Please provide your contact details below:

Telephone ____________________

Mobile ____________________

Email ____________________

For office use only

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	☐	Physiotherapy/Osteopathy/Chiropractic/Sports massage	☐
Optical	☐	Acupuncture/Homeopathy/Reflexology/Earwax removal	☐
Chiropody/Podiatry	☐	Prescription charges, inoculations and vaccinations	☐
Birth/adoption of a child	☐	Hospital consultant fees and diagnostic tests	☐

Please enclose a photocopy of the birth certificate/adoption papers.

Other (please specify) ____________________

For hospital in-patient and day case admission claims please also fill in section D overleaf.

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

Please enclose all original, named receipts with your filled-in claim form. Each receipt must be in the name of one person only. Receipts for dependent children must be in the child's name.

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

Simply fill in 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 lives 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 ask you, your GP or health care provider or practitioner for a medical report to confirm the details of a claim. By signing this declaration you consent to us doing this. If we do this, we will carry out checks in line with the Access to Medical Reports Act 1988, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, the General Data Protection Regulation (EU) 2016/679 and any national laws which relate to the processing of personal data. You must pay any fee your GP or health care provider or practitioner charges for filling in your claim form or providing any further information we ask for. These charges will be your responsibility. We are members of the Insurance Fraud Investigators Group (IFIG) and will share information about suspected fraudulent claims with other members of IFIG. For more details on how we use your personal information and your rights relating to the information we hold about you, please see our privacy policy on our website (or contact us if you would like us to send you a copy).

I consent to Sovereign using the information contained in this claim form and any supporting documentation to process my claim, and to them contacting my GP or health care provider or practitioner to request a medical report where necessary to verify my claim.

Policyholder signature ____________________ **Date** ______ /______ /__________

Please turn over...

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

For hospital claims, please fill in this section of the form and provide a copy of your hospital discharge summary with your claim, or ask the hospital or medical centre to fill in this section of the claim form with their details and details of the treatment (they should also sign and stamp the form). If you provide a copy of your hospital discharge summary, this must include the dates of admission and discharge, and the reason you were admitted. 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 __________

If maternity admission, please enter baby's date of birth _____ /_____ /__________

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/Clinic/Medical Centre stamp

Signed ____________________ **Date** ____ /____ /________

Useful checklist

Please make sure your receipt(s) details the following:

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

Before you post your claim form have you:

- ☐ Filled in 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, have you included your hospital discharge summary, or has the hospital, clinic or medical centre filled in, stamped and signed section D?

Sample of receipt

Chiropody Clinic

123 Anyroad
Any Town
BD1 1BB

Tel: 01274 000000

Mr A.N Other Dip.Phys
M.C.S.P.S.R.P
HCPC Registration Number PH12345

Mrs A Sample, 1 Sample Road
Halifax, HX1 1HS

02/01/2024 Treatment £45.00
09/01/2024 Treatment £45.00

Total received with thanks £90.00
10/01/2024

Next steps: Please return your filled-in claim form and original, named receipt(s) or documents in an envelope to Sovereign Health Care, 2nd Floor, West Wing, The Waterfront, Salts Mill Road, Shipley, Bradford BD17 7EZ. Please remember to use the appropriate postage stamps on the envelope.

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