Corporate plan claim form

Subject to our current Benefits and General Conditions.

Please return to:
Plutus Health, WHA House,
Greenwood Close, Cardiff
Gate Business Park, Cardiff,
CF23 8RD Tel: 01633 266152

plutushealth

DETAILS OF MEMBER

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Other	**Membership Number**
Full Name	**DOB** ☐☐ – ☐☐ – ☐☐
	Email
Address	**Home telephone number**
	Mobile telephone number
Post code	

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 plutushealth.co.uk/privacy-policy/

DECLARATION - This must be signed to process your claim.

By submitting this form, I can 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 Plutus Health to process health data for claim assessment, including contacting practitioners for eligibility verification.

Signature

Date

HOSPITAL INPATIENT

To be certified on discharge/completion of a 70 night stay

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

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 ☐☐ – ☐☐ – ☐☐

DATE DECEASED

IF TRANSFERRED TO A NEW HOSPITAL, COMPLETE THE 2ND INPATIENT SECTION.

HOSPITAL DAY SURGERY

Name of hospital	Date attended ☐☐ – ☐☐ – ☐☐	Signature of hospital officer
Hospital stamp	Procedure	Position Date ☐☐ – ☐☐ – ☐☐

Note: this is not to be used for overnight admissions

It is the responsibility of the claiming member or representative(s) to ensure all sections of the claim form are correctly completed before submitting to the hospital for confirmation. please note that claim forms may be checked with the hospital prior to release of payment. Hospital benefits are paid on the basis of one attendance per hospital per day.

Please turn page over for additional benefits.

MATERNITY BENEFIT (HOSPITAL OR HOME BIRTH)

To be completed by doctor, midwife or hospital officer.
Name of mother
Place of Birth
Date of birth child ☐☐ – ☐☐ – ☐☐
Male/female child
If twins or more, state number of children here and enclose birth certificates ☐
Period in hospital (if applicable) Admitted
Discharged
WE REQUIRE A COPY OF THE BIRTH CERTIFICATE AS PART OF THE CLAIM

PERSONAL ACCIDENT BENEFIT

Please send me a claim form for personal accident benefit (tick) ☐

Details of injury suffered

Date of Accident

Which benefits are you claiming for?
Please tick the relevant boxes, You can claim for multiple items on the same form

Benefit Type	Claim	Amount paid	Treatment date	Reason for treatment
Dental	✓			
Optical				
Specialist Consultation				
Chiropractic				
Podiatry				
Homeopathy				
Reflexology				
Physiotherapy				
Osteopathy				
Acupuncture				
Health Screening				

Please ensure that you complete the form with original and identifiable receipts.

Checklist before sending claim form

Have you signed the declaration? ☑

Have you included your membership number? ☑

Have you attached all relevant receipts which have your name on? ☑

Is the treatment within the last 3 months ☑