

# Personal plan claim form

Subject to our current Benefit 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 <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other	Membership Number
Full Name	DOB <input type="text"/> - <input type="text"/> - <input type="text"/>
	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/](http://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 & OUTPATIENT (EXCLUDING MATERNITY - PLEASE TURN OVER)

To be certified on discharge/completion of a 70 night stay, or for outpatient attendances

Patient's name	First	Last	DOB	<input type="text"/> - <input type="text"/> - <input type="text"/>
1st INPATIENT hospitalisation Name of hospital (official stamp)	Admitted <input type="text"/> - <input type="text"/> - <input type="text"/> Discharged <input type="text"/> - <input type="text"/> - <input type="text"/> or still in hospital	Signature and position of hospital officer	2nd INPATIENT hospitalisation Name of hospital (official stamp)	Admitted <input type="text"/> - <input type="text"/> - <input type="text"/> Discharged or <input type="text"/> - <input type="text"/> - <input type="text"/> still in hospital
	Date <input type="text"/> - <input type="text"/> - <input type="text"/>			Signature and position of hospital officer
				Date <input type="text"/> - <input type="text"/> - <input type="text"/>

## DATE DECEASED

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

OUTPATIENT attendances Name of hospital (official stamp)	Attendance Date <input type="text"/> - <input type="text"/> - <input type="text"/> Signature and position of hospital officer Date <input type="text"/> - <input type="text"/> - <input type="text"/>	OUTPATIENT attendances Name of hospital (official stamp)	Attendance Date <input type="text"/> - <input type="text"/> - <input type="text"/> Signature and position of hospital officer Date <input type="text"/> - <input type="text"/> - <input type="text"/>
PATIENTS HOSPITAL NO.		PATIENTS HOSPITAL NO.	
OUTPATIENT attendances Name of hospital (official stamp)	Attendance Date <input type="text"/> - <input type="text"/> - <input type="text"/> Signature and position of hospital officer Date <input type="text"/> - <input type="text"/> - <input type="text"/>	OUTPATIENT attendances Name of hospital (official stamp)	Attendance Date <input type="text"/> - <input type="text"/> - <input type="text"/> Signature and position of hospital officer Date <input type="text"/> - <input type="text"/> - <input type="text"/>
PATIENTS HOSPITAL NO.		PATIENTS HOSPITAL NO.	

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 outpatient benefits are paid on the basis of ONE attendance per hospital per day.

Please turn page over for additional benefits.

HOSPITAL DAY SURGERY

Name of hospital	Date of procedure	Signature of hospital officer
Hospital stamp	Description of procedure	Position
		Date

**Note: this is not to be used for overnight admissions**

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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 <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
Male/female child
If twins or more, state number of children here and enclose birth certificates <input type="checkbox"/>
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) <input type="checkbox"/>
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
Optical	<input checked="" type="checkbox"/>			
Dental	<input type="checkbox"/>			
Home Carer	<input type="checkbox"/>			
Physiotherapy	<input type="checkbox"/>			
Osteopathy	<input type="checkbox"/>			
Chiropractic	<input type="checkbox"/>			
Acupuncture	<input type="checkbox"/>			
Medical Specialist Fees	<input type="checkbox"/>			

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 or 12 month for outpatients? ☒