

Pro:Health Claim Form

Please complete using block capitals and sign where indicated

EMPLOYEE DETAILS

Employer's Name _____

Group No. _____ Registration No. _____

(Mr/Mrs/Ms/Miss) _____ Surname _____

Forenames _____ Date of Birth _____

Address _____

Postcode _____ Telephone No. _____

WHO DOES THE CLAIM RELATE TO? (If different from above)

Surname _____ Spouse/Partner

Forenames _____ Child

Registration No. _____ Date of Birth _____

BENEFIT TYPE CLAIMED (please tick box)

Please ensure the original receipts are enclosed with the claim form showing the date of treatment and the name of the patient.

Dental Specialist Consultation & Tests Optical

Acupuncture Homoeopathy Physiotherapy

Osteopathy Chiropractic

Please state condition for which treatment has been received (excluding Optical and Dental treatment)

DECLARATION (to be signed by the person claiming)

I confirm that the statements made in this claim are true to the best of my knowledge and belief and I claim benefit under my Pro:Health Membership. I also agree to supply PHSA with any additional information they may reasonably require in support of my claim.

Signed _____ Dated _____

For Office Use Only

Assessed by _____ Checked by _____

Claim No. _____ Cheque No. _____ Date _____

