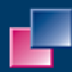 Medicaid

Claim Form

PHSA, 14 St Cuthbert's Street, Bedford MK40 3JU - Tel No. 01234 267371

1) MEMBERSHIP *(To be completed by the Subscriber)*

Group No.(if applicable) ______________ Group Name:(if applicable) ____________________ Reg No: ________

Surname: ____ (Mr/Mrs/Miss/Ms)

Forenames: ______________________________ Date of Birth: ____________________

Address: ____

____

Postcode:______________ Telephone no:______________ Email address: ____________________

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

Surname: ____ (Mr/Mrs/Miss/Ms)

Forenames: ____

Relationship to Subscriber: ____________________ Date of Birth: ____________________

2) INPATIENT / DAY CASE SURGERY BENEFITS *(To be completed by the establishment)*

OVERNIGHT STAYS

Patient's Name: ______________________________

Reason for admission and treatment given:

____

____

____

Was a surgical procedure performed? YES/NO

Admission Date: ______________

Discharge Date: ______________

Signed: ______________________

Job Title ______________________

Date: ______________________

DAY CASE SURGERY

Patient's Name: ______________________________

Reason for admission:

____

____

____

Procedure performed: ______________________________

Procedure Date: ______________

Signed: ______________________

Job Title ______________________

Date: ______________________

ESTABLISHMENT
STAMP
HERE
PLEASE

3) OTHER BENEFITS *(To be completed by the Subscriber)*

Benefit Type Claimed ***(please tick the box)***

** Answer questions 1 & 2 if you tick these benefits.

- Glasses ☐
- Sight test ☐
- Contact Lenses:Disposable ☐
- Contact Lenses:Permanent ☐
- Dental ☐
- Chiropody ☐
- Maternity/Paternity ☐
- Specialist consultation** ☐
- Physiotherapy** ☐
- Osteopathy** ☐
- Chiropractic** ☐
- Acupuncture** ☐
- Homeopathy ☐

1) If your claim is for Specialist Consultation, Physiotherapy, Osteopathy, Chiropractic or Acupuncture was the treatment undertaken on the recommendation of the patient's General Practitioner? YES\NO

2) Condition for which treatment was received ______________________________________

Please ensure the original receipts are enclosed with the claim form showing the date of treatment and the name of the patient. Credit/Debit Card receipts are not acceptable

4) DECLARATION *(To be signed for all claims)*

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 Medicaid membership. I also agree to supply PHSA with any additional information they may reasonably require in support of my claim.

Signed: ______________________________ **Date:** ______________

FOR OFFICE USE ONLY

Assessed by	Checked by	Claim No.	Cheque No.	Date

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