



MEMBER DETAILS

Group No _____ Reg No: _____

Full name (Mr/Mrs/Miss/Ms) _____

Address: _____

PATIENT

Full name (Mr/Mrs/Miss/Ms) _____ Age _____

Conditions/Symptoms: _____
_____Treatment received : _____

PATIENT'S GENERAL PRACTITIONER

I confirm that the treatment being claimed was undertaken as a result of referral from my GP whose name and address are as follows:

Full Name: _____

Address: _____

DECLARATION

The treatment was recommended by my GP and the expenses cannot be recovered from any other source.

Signature: _____

The enclosed accounts are: **paid** **unpaid**

FOR OFFICE USE ONLY

	Inpatient		Outpatient		Benefit	
	£	p	£	p	£	p
Acc. Charge From:						
To:						
Theatre Charge:						
Drugs & Dressings						
Surgeon/Physician						
Anaesthetist						
Consultation						
Radiology						
Pathology						
Manipulative Therapy						
Other						
Totals:						

Claim No.	DOJ	Paid to	Preclusions	Scale	Renewal Date	Assessed	Checked	Chq. Authorised