

# HOSPITAL PLAN INSURANCE SERVICES

Regd. in England No. 2100356 Regd. Office - Tel: (020) 8662 8183

Please complete and return to: ADDRESS HPIS, Claims Department, 96 George Street, Croydon CR9 1BU  
EMAIL claims@hpis.co.uk  
FAX 020 8688 9202

CLAIMANT'S NAME \_\_\_\_\_ POLICY NUMBER(S) \_\_\_\_\_  
ADDRESS \_\_\_\_\_ HOME TELEPHONE NUMBER \_\_\_\_\_  
POSTCODE \_\_\_\_\_ MOBILE NUMBER \_\_\_\_\_

CLAIMANT'S STATEMENT To be filled in by the patient/subscriber. Please use a separate form for each Hospital stay.

## Part 'A'

Patient's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date entered/attended Hospital \_\_\_\_\_ Still in Hospital on \_\_\_\_\_ Date Discharged \_\_\_\_\_  
Name of Hospital \_\_\_\_\_ No. of Nights in Hospital \_\_\_\_\_  
Hospital Address \_\_\_\_\_  
Ward(s) \_\_\_\_\_ Give names of Doctors \_\_\_\_\_  
Give details of condition/reason for hospital confinement/attendance \_\_\_\_\_  
Date of first symptoms \_\_\_\_\_ Date medical advice sought \_\_\_\_\_ If childbirth-Date born \_\_\_\_\_  
If Surgical, specify precise operation(s) performed \_\_\_\_\_  
If accidental injury state when, where and how it happened \_\_\_\_\_ Accident Date \_\_\_\_\_  
Specify any resulting fracture(s) \_\_\_\_\_  
Specify any resulting permanent disability \_\_\_\_\_  
Give details of any significant illnesses or medical conditions, past and present \_\_\_\_\_  
Name of patient's family doctor \_\_\_\_\_ Surgery Tel. No. \_\_\_\_\_  
Surgery Address \_\_\_\_\_ Postcode \_\_\_\_\_

**WARNING – YOUR CLAIM CANNOT BE PROCESSED WITHOUT PART C (PAGE 2) BEING COMPLETED**

**Part 'B'** This section is to be completed by the Hospital Medical Records department before the claim form is returned

### What type of hospital / facility has this patient been treated in?

(Please give dates spent in each category)

- Acute Hospital
- Mental Illness / Psychiatric Facility
- Long Term Nursing Unit / Nursing Home
- Rehab Centre / Hospital
- Community / Cottage Hospital
- GP Led Hospital
- Convalescence Home
- Extended Care Home
- Hospice
- Under Doctors \_\_\_\_\_

I certify that the above named was treated in this Hospital as an:-

In-Patient  Day Case/A&E

Date Admitted/Attended \_\_\_\_\_  
Still In-Patient on \_\_\_\_\_  
Date Discharged \_\_\_\_\_  
Dates of Home-Leave \_\_\_\_\_

Authorised Signature \_\_\_\_\_ Position Held \_\_\_\_\_ Date \_\_\_\_\_

**Official Stamp**

HOSPITAL NO \_\_\_\_\_

