Freedom Health Insurance

Claim for Benefits

PART B

To be completed by your consultant specialist for further treatment and / or investigations. Please use **BLOCK CAPITALS**.

Patient's name:

Address:

Postcode:

Policy number: Claim number:

PLEASE NOTE

Providing false information, misleading information or knowingly omitting pertinent information is an offence and will be reported to the appropriate authorities, including the GMC. Copies of the patient's records may be requested at a later date.

Your name:

Hospital address:

Postcode:

GMC number: Tel number (inc area code):

Speciality:

Has the patient been referred to you by his / her general practitioner? Yes ☐ No ☐

Name of general practitioner:

To the best of your knowledge, when did the patient first become aware of these signs or symptoms? D D M M Y Y Y Y

When did the patient first consult you regarding these signs or symptoms? D D M M Y Y Y Y

What is the diagnosis?

What is the ICD10 Code of the diagnosis?

Please advise treatment to date and proposed treatment during the next six months. Include OPCS codes if applicable.

Treatment Description	OPCS Code	In/Day Patient or Outpatient?

At which hospital will the treatment be carried out?

Date, or proposed date, of admission: D D M M Y Y Y Y

Anticipated date of discharge: D D M M Y Y Y Y

DECLARATION (To be signed by the patient's specialist)

I declare, to the best of my knowledge and belief, that the statements I have made above are full, true and complete.

Signature of specialist: Date: D D M M Y Y Y Y

When the claim form is complete, please send it to: Claims Department, Freedom Health Insurance, Bourne Gate, 25 Bourne Valley Road, Poole BH12 1DY. Phone: 0800 999 2013 or 01202 756 350. Fax: 01202 756351 Email: claims@freedomhealthinsurance.co.uk Website: www.freedomhealthinsurance.co.uk.