Prison Officers' Medical Aid Society

397e North Circular Road, Dublin 7. Phone (01) 830 8963

HOSPITAL CLAIM FORM

NOTES:	
(1) Use this form for In-Patient expenses only i.e. Hospital maintenance and fees. The Society will pay these bills for you providing they are submitted within 3 *months*.	(2) Photocopies of receipts will not be accepted. (3) Original bills cannot be returned.

Name .....

Address .....

If this claim or part of it is in respect of dependants, they must be named in the spaces provided here.

Spouse / Partner:- .....

Children:- (1) ..... (2) ..... (3) .....

(4) ..... (5) ..... (6) .....

THIS CLAIM WILL BE RETURNED TO YOU IF BOTH SECTIONS A & B ARE NOT COMPLETED

SECTION A

Please insert the total amount of your claim in the appropriate box below.

HOSPITALISATION

		MEMBER	SPOUSE	CHILD	NO OF BILLS
1. Maintenance:	**General Hospital**				
	Professional Fees				
2. Maintenance:	**Maternity** *(See Note 1 below)*				
	Professional Fees				
3. Maintenance:	**Dental** *(See Note 2 below)*				
	Professional Fees				
	TOTALS				

Note (1) PLEASE GIVE NAME(S) AND DATE(S) OF BIRTH OF NEW DEPENDANT(S) AND SUPPLY BIRTH CERTIFICATE
(2) HAVE YOU BEEN GRANTED PRIOR APPROVAL IN RESPECT OF IN-PATIENT DENTAL TREATMENT? YES/NO
IF THE ANSWER IS NO - PLEASE CONTACT THE MANAGER / ASSESSOR *BEFORE* SUBMITTING THIS CLAIM

SECTION B

Is this claim or any part of it related to:-	**YES**	**NO**
(1) General Third Party? eg. motor accident.	☐	☐
(2) Personal injuries criminally inflicted? eg. Assault on or off duty	☐	☐
(3) Injury/Accident on duty?	☐	☐
(4) Injury, illness or disablement, directly or indirectly caused by war or civil disturbance?	☐	☐

Note carefully:

If the answer to any of the above is "YES" you must contact the Manager/Assessor *BEFORE* submitting this claim.

WARNING: *DO NOT WRITE ON BILLS OR ALTER THEM IN ANY WAY.*
ENSURE THAT ALL DOCUMENTS IN SUPPORT OF YOUR CLAIM ARE IN ORDER AS YOU HAVE TO ACCEPT RESPONSIBILITY FOR THEM.

Declaration: I declare that the attached bills relate only to me and/or my registered dependants all of whom are members of the Society and that the information supplied on/with this claim is correct.

- THE RULES PROVIDE FOR SERIOUS PENALTIES FOR FRAUDULENT CLAIMS -

Signed ..... Pay No ..... Date .....
(MEMBER)

Personnel No ..... (If retired)

AH3066

FOR OFFICE USE ONLY

M/S/C	CODE	NOTES	DAYS	AMOUNT	REF	CLAIM NO.

WITHHOLDING TAX NETT

Dr/Mr	( )	A	
Dr/Mr	( )	B	
Dr/Mr	( )	C	
Dr/Mr	( )	D	
Dr/Mr	( )	E	
Dr/Mr	( )	F	
Dr/Mr	( )	G	
Dr/Mr	( )	H	

SUMMARY

(A) Pay Hospital (1): € ..... (2):€ ..... (3):€ .....

(B) Pay Ambulance: € .....

Advise Member: Balance € ..... due to: .....

Balance € ..... due to: .....

ASSESSED BY ..... **DATE** .....