your | HEALTH

ST. CHRISTOPHER HEALTH FUND

HOW TO MAKE A CLAIM

The Rules of the Fund specify how claims should be made (see Section 6 – Applications for Assistance) and excluded items of expenditure (see Section 7 – Exclusions). For ease of reference the key points are summarised below:-

- Applications for assistance from the Fund should be made before expenses are incurred, in writing, by telephone, or e-mail, to the Fund secretariat.

- Where applicable, claims should be made under private medical insurance (PMI) before an application for assistance is made to the Fund. If part of the costs incurred is covered by PMI, evidence for this amount must be provided.

- If a claim is successful, the level of benefit payable shall be that applying on the date on which treatment takes place.

- Claims are subject to a calendar year limit.

- Claims must be supported by invoices. These should be on the headed paper of the practitioner and receipted by the practitioner. They should clearly state the medical condition and the treatment provided, date of treatment and name of member receiving the treatment.

- Invoices must be less than six months old. Subject to this time limit, and wherever possible, Members should submit all invoices relating to a particular course of treatment at the same time.

- Expenses incurred within the first 6 months of registration with the Fund will not be covered except for:
    - a new born child
    - the widow/widower of Civil/Registered Partner of a deceased member who has applied to assume membership under Rule 4(g)
    - a member who has paid a joining fee who has immediate cover.

- The following claims will be refused:
    - treatment provided by a medical practitioner who is not registered with a recognised national medical association
    - private treatment provided by a General Practitioner
    - treatment received outside the United Kingdom whilst on holiday or business
    - childbirth
    - dentistry
    - out-patient optical treatment
    - chiropody
    - cosmetic treatment
    - nursing care
    - convalescence
    - out-patient drugs, medicines, remedies
    - medical appliances, other than in exceptional circumstances
    - other treatment considered to be outside the scope of the Fund

- Although the costs of nursing care and convalescence are not covered by the Fund, the Committee is generally sympathetic to the problems arising in this area, particularly for older members. The Committee is willing to consider such requests.

- The Committee reserves the right to review periodically the payment of costs in cases where treatment is long term.

Making a Claim: Checklist

- Include original documentation from hospital or consultant, on their headed note paper. This must clearly state:-
    - ✓ the name of the patient
    - ✓ the cost of the treatment
    - ✓ the treatment received (eg consultation, surgery)
    - ✓ the date of the treatment

- The documentation should be accompanied by a covering letter which must specify your (ie the claimant's) contact details including telephone number and/or email address so that any queries can be resolved quickly. If you want the original documentation from the hospital or consultant returned to you, please specify this in the covering letter.

- If the claim relates to a medical insurance shortfall, all relevant documentation (originals) must be provided so that the amount payable by the Fund can be calculated.

- Do not send any credit card receipts as part of your claim package.