

FUNDING FOR TREATMENT IN THE EEA – APPLICATION FORM

Please note: NHS England can only process claims for residents ordinarily resident in England.

Reimbursements will only be granted for eligible treatment costs (i.e. not travel / accommodation).

S2 route applications must be authorised by NHS England before treatment. The provider must be a state provider (*the onus is on the applicant to confirm whether the provider is in the state sector and to check if they will accept an S2 form*).

Directive route applications must be authorised by NHS England prior to treatment if subject to “prior authorisation”. Otherwise claims can be submitted post treatment and the provider can be state or private.

Please read the accompanying guidance before completing this form, available at:

<http://www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment>

The applicant is responsible for providing accurate and complete information with the application. This will form the basis of the decision making process.

Part 1: Application Route

Before or after treatment	<input type="checkbox"/> I am applying before receiving treatment in another EEA country
	<input type="checkbox"/> I am applying after receiving treatment in another EEA country
Application route	<input type="checkbox"/> I want to apply for funding via the S2 route (before treatment only)
	<input type="checkbox"/> I want to apply for funding via the Directive route (before or after)
	<input type="checkbox"/> I am unsure which funding route to use

Part 2: Confirmation of the Applicant

Are you (the applicant) also the patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - also complete Parts 8 & 9
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Part 3: Patient Details

Family name		First name(s)	
Date of Birth		Gender	
Telephone number		Email	
NHS number			
Permanent address in England (inc. postcode)			
Alternative address for correspondence (if applicable)			
GP Name / Registered GP practice:			
GP address (inc. postcode)			

Part 4: Treatment Details

1.	What is the <u>DIAGNOSED</u> medical condition for which the patient has received / is planning to receive treatment(s) abroad?	
2.	Describe the <u>TREATMENT(S)</u> the patient has received / is planning to receive abroad.	
3.	What are / were the specific <u>DATE(S)</u> for the treatment(s) abroad <i>(where applicable)</i>?	
	In-patient stays (i.e. overnight stays in hospital)	
	Out-patient appointments (e.g. day case appts/ clinics)	
	Other appointments (e.g. check-ups, physiotherapy)	
	Diagnostics tests (e.g. Blood tests / scans)	
	Equipment / Appliances issued (e.g. walking aids, hearing aids)	
	Drugs / Medication paid for	
	Other, please specify	
4.	Is a Clinician's letter / report attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<p><i>A letter / report <u>must</u> be attached from the patient's clinician (e.g. GP/ Consultant), describing the patient's condition / diagnosis, and confirming the medical need for the treatment(s).</i></p> <p>S2: This must be from a UK clinician and must also support the treatment(s) being carried out in the proposed country.</p> <p>Directive: This must be from an EEA clinician (which can include a UK clinician).</p> <p><i>If the letter is provided by a clinician from another EEA country, please ensure this is in English or that an English translation is provided.</i></p>	

5.	Treatment costs - what are the total costs of the treatment?
	Estimated - if before treatment(s): Total amount claimed - if after treatment(s):
6.	What treatments (if any) are you already receiving / have received, for this condition, and please indicate if any are / were under the NHS?
7.	Have you applied for funding, via the NHS, for this treatment before? If so, was it approved?
	Applied for funding: <input type="checkbox"/> Yes <input type="checkbox"/> No Funding Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No Funding Approved: If yes, provide further details, including dates / reference numbers: If no, provide the reason why funding was not approved:
8.	Is the claim in relation to emergency / urgent (unplanned) treatment abroad?
	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, and the treatment was provided by a state provider, did you try to use your EHIC card? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't have an EHIC card. <input type="checkbox"/> Not sure if state If you tried to use your EHIC card, was it accepted by the provider? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please record the reason why the state provider would not accept it:
9.	Are you seeking treatment abroad because of a medical delay in being treated by the NHS?
	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is this delay deemed to be "medically unacceptable" and assessed as such by a UK clinician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide evidence: <input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Are you expecting to receive follow-up treatment from the NHS when you return?
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part 5: Treating Clinician / Provider Details

11.	The provider is in the <i>(please tick)</i> <input type="checkbox"/> Private sector or <input type="checkbox"/> State sector	
12.	Please provide details of the main establishment(s) where the patient was treated / is going to be treated (If this involves more than one establishment, please provide details on a separate sheet.)	
	Treating clinician name	
	Name of establishment	
	Address	
	Country	
	Telephone number	
	Email address	
	Fax number	
13.	Are you also claiming reimbursement for <u>prescribed drugs</u> paid for in another EEA country <i>(Post treatment claims only)?</i>	
	<input type="checkbox"/> Yes ⇒ Go to Question 13 <input type="checkbox"/> No ⇒ Go to Question 14	
14.	Please provide details of the <u>pharmacy</u> that dispensed the drugs <i>(Post treatment claims only)</i>	
	Name of establishment	
	Address	
	Country	
	Telephone	
	Email	
15.	Is the patient exempt from any NHS charges (e.g. prescription / dental charges)?	<input type="checkbox"/> No <input type="checkbox"/> Yes ⇒ <i>Please provide details and reason for exemption:</i>

Part 6: Itemised Reimbursement Claims (post treatment)

In the table below please list all the expenditure for which you are claiming reimbursement

Reimbursement cannot be made without proof of payment. Please attach the originals of all bills, invoices and receipts. Additionally, please provide English translations, where these are not in English.

Date of receipt	Establishment paid	Treatment covered	Amount paid (in state currency)
Please continue on an additional sheet if you need more space and tick here <input type="checkbox"/>	TOTAL CLAIMED:		

Part 7: Further supporting information to be recorded here
(please reference Part / Question number)

Part 8: Declaration by the Applicant

I declare that all the information I have provided is correct and complete. I understand and accept that if I knowingly withhold information or provide false or misleading information, I may be liable to prosecution and/or civil proceedings. I consent to the disclosure of all information relating to my application to and by NHS England, the Department of Health, the Department of Work and Pensions, NHS Protect and other NHS organisations necessary for the processing and verification of this claim and the investigation, prevention, detection and prosecution of fraud.

I understand that the NHS is not liable for the care received abroad when funded via the S2 or Directive route.

By ticking the following box, I confirm that the patient is normally resident in the UK and entitled to receive NHS services:

I declare that I am the patient / I am acting with the consent of the patient / I am legally empowered to act on behalf of the patient (**delete as appropriate**)

Name of applicant			
Signature of applicant		Date	

Part 9: Details of the Applicant (if different from the patient)

Family name		First name(s)	
Relationship to patient		Title	
Telephone number		Email	
Applicant's address (for correspondence)			

Part 10: Declaration by the Patient (required if different from applicant)

I hereby give permission for the person identified as the Applicant in Parts 8 and 9 of this form to make this application on my behalf. I understand that the NHS is not liable for the care received abroad when funded via the S2 or Directive route.

If applying for reimbursement of costs, I hereby confirm that I have received the treatment described and understand that the applicant will receive any reimbursement issued.

Name of patient			
Signature of patient		Date	

Please send your completed form and accompanying documents to the following address:

**European Cross Border Healthcare Team
NHS England
Fosse House, 6 Smith Way
Grove Park, Enderby
Leicester, LE19 1SX**

Or email: england.europeanhealthcare@nhs.net

Please note: It can take up to 20 working days for an application to be processed and a decision to be made. This may however take longer, if your application is not complete and additional information needs to be requested. You will be informed of the outcome of your application once a decision has been reached. If approved, the reimbursement can take up to a further 30 working days to be processed.

Please only send the requested supporting information.