NHS England

FUNDING FOR TREATMENT IN EUROPE
APPLICATION FORM

THERE ARE SUPPORTING GUIDANCE NOTES (ON NHS CHOICES OR AVAILABLE FROM THE EUROPEAN TEAM) TO HELP YOU COMPLETE YOUR APPLICATION FORM.

IF YOU DO NOT FOLLOW THE SUPPORTING GUIDANCE, THE LIKELIHOOD IS THAT YOUR APPLICATION MAY NOT BE COMPLETE OR ACCURATE (WHICH MAY DELAY YOU RECEIVING A DECISION AND MAY EFFECT YOUR ELIGIBILITY TO FUNDING).

PLEASE ALSO COMPLETE THE APPLICATION CHECKLIST (PART 13) – BEFORE SUBMITTING YOUR APPLICATION.

Part 1: Application Route

Treatment	**On what basis is the treatment being provided?** **Private system or State system**
Before / after treatment	I am applying **before** receiving treatment in another EEA country I am applying **after** receiving treatment in another EEA country
Application route *(please tick one box only.* *Complete a separate application form for each category)*	☐ **S2:** I want to apply for funding via the **S2** route *(before treatment only in the state system)* ☐ **Directive - Specialised:** I want to apply before treatment, for funding for a *specialised* treatment subject to prior authorisation *(state or private)* ☐ **Directive - pre:** I want to apply before treatment, for funding for treatment not classed as 'specialised' (*state or private)* ☐ **Directive - post:** I want to apply after treatment, for funding for treatment not classed as 'specialised' (*state or private)*

Part 2: Patient Details (Please record clearly, in BLOCK CAPITALS)

Family name					**First name(s)**					
Date of Birth					**Sex**					
Telephone number(s)										
Email address										
NHS number										*This is normally a 3-3-4 digit format*
National Insurance No										
Permanent / settled address in England *(inc. postcode) for correspondence*										

Alternative address for correspondence *(only if applicable, please state reason)*

GP Name / Registered GP practice *(this must be the GP you were registered with at the time of the treatment you are applying for):*

GP address (inc. postcode)

Are you exempt from any NHS charges (e.g. prescription / dental / ophthalmic charges)?

☐ **Yes** ☐ **No**

If these are relevant to your application treatments, please record details.

☐ **No**
☐ **Yes** ⇨ *Please tick which* ***type(s) of*** *exemption are relevant to your application:*

☐ Prescription charges

☐ Dental treatment

☐ Sight tests ☐ Glasses / contact lenses

☐ Other: ______________________________

Reason for exemption: ______________________________

☐ Evidence of exemption provided

For further guidance on exemptions (document HC12) can be found on NHS Choices.

Part 3: Residence

By ticking the following box, I confirm that I am ordinarily resident in England (living lawfully, on a settled basis), and entitled to receive NHS services: ☐

Are you currently residing at the settled address you have provided on page 1? ☐ **Yes** ☐ **No**

Is this address your settled residence at the time of treatment? ☐ **Yes** ☐ **No**

If **No**: Where are you currently residing (address / country)? ______________________________

____

How long have you been there? ______________________________

How long are you intending to reside there? ______________________________

What is the reason for you not currently residing at your settled address (e.g. work, study, health, other)? ______________________________

Part 4: Treating Clinician / Provider Details

Provide details of the main establishment(s) in the EEA, where you were treated / are going to be treated (in relation to the treatments for which you are applying for funding). If this involves more than one establishment, please provide details on a separate sheet.

Treating clinician name	
Name of establishment	
Address	
Country	
Telephone number(s)	
Email address	
Fax number	

Part 5: Treatment Details
(in relation to this application)

a)	**Are you applying BEFORE you have had the treatment?** ☐ **Yes** ☐ **No**
b)	**Is the application in relation to emergency / urgent (unplanned) treatment abroad in the State sector?** ☐ **Yes** ☐ **No**
	If Yes, did you try to use your European Health Insurance Card (EHIC)? ☐ **Yes** ☐ **No** ☐ **Didn't have an EHIC card** If you tried to use your EHIC card, was it accepted by the provider? ☐ **Yes** ☐ **No** If no, please record the reason below why the provider would not accept it:
c)	**Did you have travel insurance?** ☐ **Yes** ☐ **No**
	If Yes, have you approached your travel insurance company for any parts of your claim for treatment costs? ☐ **Yes** ☐ **No** If no, provide details as to why not or why you could not claim:

d)	**What is the <u>DIAGNOSED</u> medical condition for which you have received / are planning to receive treatment(s) abroad?**
e)	**Describe the <u>TREATMENT(S)</u> you have received / are planning to receive abroad.**
f)	**Please make sure you provide for:** • **ALL application funding routes (EU Directive and Specialised and S2):** An EEA clinician's letter / report confirming the medical need for the treatment(s): • **Specialised and S2 applications only:** Written support from an EEA clinician which states how soon you need your treatment and why (based on their clinical assessment), ***Undue Delay (this is where the NHS cannot provide the treatment / equivalent requested, in a medically justified timeframe, for your diagnosis / condition)*** *Please note that "Undue Delay" is a routine criteria for S2 and discretionary for Specialised treatments. This means we will, where necessary, contact the relevant NHS Commissioner to confirm treatment timeframes under the NHS.* • **S2 only:** Written confirmation from the provider that (1) they will accept an S2, (2) planned treatment dates, (3) estimated costs.
g)	**<u>S2, Pre-directive and specialised treatments:</u> What are the estimated costs of the treatment (because you are applying before treatment)?**

<table>
<tr><td>**h)**</td><td colspan="4">**What are / were the specific DATE(S) for the treatment(s) abroad?** *(complete where applicable)*</td><td>**Receipt no.** **(ref Section 8 - post treatment)**</td></tr>
<tr><td>**In-patient stays** (i.e. overnight stays in hospital)</td><td colspan="4"></td><td></td></tr>
<tr><td>**Day case appointments** (e.g. day case surgery)</td><td colspan="4"></td><td></td></tr>
<tr><td>**Out-patient appointments** (e.g. clinics / consultations)</td><td colspan="4"></td><td></td></tr>
<tr><td>**Other appointments** (e.g. physio)</td><td colspan="4"></td><td></td></tr>
<tr><td>**Diagnostics tests** (e.g. Blood tests / scans)</td><td colspan="4"></td><td></td></tr>
<tr><td>**Equipment / Appliances issued** (e.g. walking aids, hearing aids)</td><td colspan="4"></td><td></td></tr>
<tr><td rowspan="6">**Drugs / Medication paid for separately**

Continue on a separate sheet if required</td><td>*Medication Name*</td><td>*Type (e.g. tablets, gel, cream, liquid)*</td><td>*Strength (e.g. 50mg)*</td><td>*Quantity (e.g. 1 x box 50 tablets, 1 x 100ml bottle)*</td><td></td></tr>
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<tr><td>**Other, please specify**</td><td colspan="4"></td><td></td></tr>
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Part 6: Application details – General	
a)	**Please provide details of whether you have been treated before for this condition and whether it was on the NHS or by another provider (e.g. private / in Europe).**
b)	**Have you applied for funding, via the NHS, for this treatment before?**
	Applied for funding: ☐ **Yes** ☐ **No** Funding approved: ☐ **Yes** ☐ **No** If Yes, provide further details, including dates / reference numbers (previous EU reference number or other NHS reference number e.g. IFR): If Yes - Details: ______________________________ If No, provide the reason why funding was not approved:

Part 7: Supporting relevant information (to application) (continue on a separate sheet if needed)

Part 8: Post Treatment Costs / Proof of Payment

Please note that you will only be reimbursed for items / treatments clearly recorded in the table below and supported by acceptable proof of payment and clinical / medical documentation. Please also number / batch your receipts to match your entries below and record the receipt number clearly against your treatment details in Part 5h above.

Proof of Payment (POP) – documentation					
Receipt Number	Date of receipt	Establishment paid	Treatment(s) covered	Record amount in currency paid	Method of Payment
e.g. 1)	20/01/14	Hôpital Européen Georges-Pompidou	Blood test	E.g. 1,000 Euros	E.g. cash, card
1)					
2)					
3)					
Please continue on an additional sheet if you need more space and tick here ☐			TOTAL CLAIMED		

Part 9: Declaration by the Patient

I declare that all the information 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 for Work and Pensions (DWP), NHS Protect and other NHS organisations / external parties, 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.

If applying for reimbursement of costs, I hereby confirm that I have received the treatment(s) described and understand that the person who received and paid for treatment(s), will normally receive any reimbursement due.

I also hereby give permission for the person identified as the Applicant in Part 9 of this form to make this application on my behalf (if applicable).

Name of patient			
Signature of patient		**Date**	

Part 10: Confirmation of the Applicant

Are you (the patient) also the applicant?	☐ **Yes** ☐ **No –** Please complete Parts 11 & 12

Part 11: Declaration by the Applicant

I declare that I am applying 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 12: Details of the Applicant

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

Please note, even if you are acting on behalf of the patient, proof of the patient's residence, as per the guidance notes, must still be submitted. Parents applying on behalf of their children are required to submit evidence of their own residence for the permanent address given (and the signature of the child, as the patient, is not required).

Part 13: Application Check List (complete this section prior to submitting your form)			
Tick	Documents required to support application form	Directive	S2
☐	**Proof of residency documents for your permanent / settled address in England.**	√	√
☐	**EEA Clinicians letter supporting diagnosis and medical need for treatment** *(original copy and English translation required).*	√	√
☐	**S2 and Specialised treatments only:** Written support from an EEA clinician which states how soon you need your treatment and why (based on their clinical assessment). *(original copy and English translation required).*	√ (specialised only)	√
☐	**Written confirmation from the EEA provider that they will accept an S2, planned treatment dates & estimated costs.**		√
☐	**Post treatment: Invoices and receipts / proof of payment, for items included in Part 8** *(plus translation(s)*	√	
☐	**Evidence of exemption for relevant patient charges**	√	
☐	**All sections of the application form completed.**	√	√
☐	**Signatures** *(patient / applicant).*	√	√
☐	**Security Question and Answer:** *(please provide for phone call ID verification)* **Q:** ______________ **A:** ______________		

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

Telephone: 0113 8249653

Please note: It can take up to 20 working days for a fully completed application to be processed and an entitlement decision to be made.