FUNDING FOR TREATMENT IN THE EUROPEAN ECONOMIC AREA (EEA) APPLICATION FORM

Guidance Notes

This form can be completed by a person other than the patient e.g. a family member or a clinician. However, all the information provided should be about the patient. (Parts 9 and 10 of this form require the applicant to provide details if they are applying on behalf of the patient). We can only communicate with the patient / applicant about the application, unless we have the written consent from the patient regarding anyone else they wish us to communicate with.

Please read the accompanying guidance, on NHS Choices, before completing this form:
http://www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment

Notes on the S2 application route:

- Applications must be authorised by the NHS England European Cross Border Health Care Team before treatment.
- The treatment must be provided in the state healthcare system of the other country.
- Please note that the healthcare providers (from this point referred to as "providers") may be either private or state providers. However, some private providers offer treatment for the state system and some state providers offer treatment privately.
- It is therefore very important that you check whether the provider will accept an S2 form to fund the treatment(s) you are applying for.
- Applications for Maternity S2 funding must be made directly to the Department for Work and Pensions (DWP), and not to this team (see NHS Choices for further information).
- S2 applications cannot cover experimental treatments or drug trials.

EU Directive application route:

- Reimbursement can only be made for treatments that would be available to you under the NHS. If you are unsure whether a treatment would be available to you under the NHS, please contact your local Clinical Commissioning Group (CCG) or NHS England before you receive treatment or apply for funding. Find out more on entitlements here: www.nhs.uk/nhsengland/healthcareabroad/plannedtreatment/pages/article56.aspx
- Depending on the complexities of your individual case, it may be necessary to request further information for your application to be assessed correctly.
- Most applications can be made either before or after treatment. However, applications for 'specialised' treatments require 'prior authorisation' and must be approved by NHS England prior to treatment. A list of such treatments can be found on NHS Choices.
- The treatment received can be in either the state or private healthcare system

Reimbursement: Only treatment costs can be assessed for reimbursement. Travel and accommodation will not be reimbursed, including for those who may be accompanying you on your trip abroad. Translation costs are also not covered.

Proof of residence: You must send 2 examples of official evidence showing you are resident at the stated address, covering the treatment period (see checklist, Part 11, 1). NHS England can only process applications for patients ordinarily resident in England.

You are responsible for providing accurate and complete information in the application. This will form the basis of the decision making process. Incomplete applications cannot be processed.
Please ensure that you complete the application check list before submitting the form.

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 - 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)* ☐ **Directive - Specialised:** I want to apply before treatment, for funding for a *specialised* treatment subject to prior authorisation *(state or private)*

Medical Delay	**Are you seeking treatment abroad because of a medical delay in being treated by the NHS?** ☐ **Yes** ☐ **No**
	If Yes, please provide evidence that this delay was deemed to be "medically unacceptable" and assessed as such by a UK NHS clinician.

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 address in England *(inc. postcode)*											
Alternative address for correspondence *(if applicable)*											
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)?	☐ **No** ☐ **Yes** ⇨ *Please tick which **type(s) of** exemption:* ☐ Prescription charges ☐ Dental treatment ☐ Sight tests ☐ Glasses / contact lenses ☐ Other: _____ Reason for exemption: _____ ☐ Evidence of exemption provided For further guidance on exemptions (HC12): *http://www.nhs.uk/NHSEngland/Healthcosts/Documents/HC12%20April%202013.pdf*

Part 3: Treating Clinician / Provider Details

Please 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 separately sheet.

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

Part 4: Treatment Details (in relation to this application)	
a)	**What is the <u>DIAGNOSED</u> medical condition for which you have received / are planning to receive treatment(s) abroad?**
b)	**Describe the <u>TREATMENT(S)</u> you have received / are planning to receive abroad.**
c)	**Is a Clinician's letter / report attached:** ☐ **Yes** ☐ **No**
	A letter / report <u>must</u> be attached from your Clinician, describing your condition / diagnosis, and confirming the medical need for the treatment(s). The letter / report must clearly state why the treatment received will be / was needed. **For S2 applications**: 1) The clinician's letter / report must be from a UK NHS Consultant, on NHS letterhead, and must support the treatment(s) being carried out in the proposed country. 2) We also require written confirmation from the provider of: the agreed treatment(s), treatment dates and estimated costs. **For Directive applications:** The letter / report must be from an EEA Clinician e.g. Consultant / GP (which includes a UK Clinician). *If the letter / report is provided by a Clinician from another EEA country, please ensure this is in English or that an English translation is provided. You may provide an accurate translation yourself, but please sign and date.*

d)	**What are / were the specific <u>DATE(S)</u> for the treatment(s) abroad?** *(complete where applicable)*				
	In-patient stays (i.e. overnight stays in hospital)				
	Day case appointments (e.g. day case surgery)				
	Out-patient appointments (e.g. clinics / check-ups / consultations)				
	Other appointments (e.g. physiotherapy)				
	Diagnostics tests (e.g. Blood tests / scans)				
	Equipment / Appliances issued (e.g. walking aids, hearing aids)				
Continue on a separate sheet if required	**Drugs / Medication paid for**	*Medication Name*	*Type (e.g. tablets, gel, cream, liquid)*	*Strength (e.g. 50mg)*	*Quantity (e.g. 1 x box 50 tablets, 1 x 100ml bottle)*
	Other, please specify				
e)	**Are you applying before treatment?** ☐ **Yes** ☐ **No** If Yes go to (f), below, if No go to (g)				
f)	**What are the estimated costs of the treatment?**				

Post Treatment Costs

Please note that you will only be reimbursed for items / treatments clearly recorded in the table below and supported by proof of payment documentation, as detailed below.
Please also number / batch your receipts to match your entries.
All of the entries must also be covered by a clinician's letter / report (inc. medication).
You must also provide English translations, where these documents are not in English.

g)	**Proof of Payment (POP) – documentation** Record the method of payment in the end column, providing the following evidence:				
Cash		Invoice – *Original*	Cash receipt from the provider showing payment – *Original.*		
Credit Card		Invoice – *Original*	Credit card statement showing transaction to provider - *Copy*		
On-line transfer		Invoice – *Original*	Bank statement showing transaction to provider - *Copy.*		
Cheque		Invoice – *Original*	Receipt & bank statement showing cashed cheque - *Copy.*		
Receipt Number	**Date of receipt**	**Establishment paid**	**Treatment(s) covered**	**Amount paid (state currency)**	**Method of Payment**
e.g. 1)	**20/01/14**	**Hôpital Européen Georges-Pompidou**	**Blood test**	**10,00 Euros**	**E.g. Cash**
1)					
2)					
3)					
Please continue on an additional sheet if you need more space and tick here ☐			**TOTAL CLAIMED**		

h)	**What treatments (if any) are you already receiving / have received, for this condition, and please indicate if any are / were on the NHS?**
i)	**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): _____ Details: If No, provide the reason why funding was not approved:
j)	**Is the application in relation to emergency / urgent (unplanned) treatment abroad?**
	☐ **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:
k)	**Did you have travel insurance?** ☐ **Yes** ☐ **No**
	If yes, please state why you are applying for NHS funding rather than making an insurance claim.

Part 5: 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 permanent address you have provided on page 2? ☐ **Yes** ☐ **No**

Is this address your permanent 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 permanent address (e.g. work, study, health)? _____

Part 6: Supporting information

(please reference Part / Question number and continue on a separate sheet if needed)

Part 7: 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 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 8: Confirmation of the Applicant

Are you (the patient) also the applicant?	☐ **Yes** ☐ **No –** Please complete Parts 9 & 10

Part 9: 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 10: 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 11: Application Check List

(you must complete this section prior to submitting your form)

1. ☐ **2 x Proof of residence for permanent address (covering treatment period).** *One must be a bank statement (showing day to day transactions), along with one other official document linked to your residency e.g. utility bill / council tax bill or tenancy / rental agreement. Please contact us for further advice, if required.*

2. ☐ **Clinicians letter supporting medical need** *(English translation required).*

3. ☐ **S2 only – written confirmation from the provider of the treatment(s) of the: agreed treatment(s), dates and the estimated costs.**

4. ☐ **Invoices and receipts / proof of payment, for items included in Part 4 (Section g)** *(English translation(s) required).*

5. ☐ **Evidence of exemption from patient charges** *(if applicable).*

6. ☐ **All sections of the application form completed.**

7. ☐ **Signatures** *(patient / applicant).*

8. ☐ **Security Question and Answer: Q:** _____
   (please provide for phone call ID verification **A:**_____

Supporting Documentation

This team only requires the original receipts / Proof of Payment documents, as outlined in section 4(g). All other supporting documentation can be copies.

We cannot accept responsibility for documents lost in transit.

Translations should be signed / dated / stamped.

Please note that this application will not be processed until all of the necessary supporting information has been received. Incomplete applications will therefore be put on hold, and not processed, until complete.

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 a fully completed application to be processed and a decision to be made. 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.