

Please Note:

**Claim year 1st January to 31st December.
Please submit claim after end of December**

The claim covers:

- GP fees (subject to limit) covering any consultation, testing or treatment including infections, blood tests, BP monitoring, PSA screening and Smear Tests
- Prescribed pharmacy (subject to limit) in respect of any one month.
- Acupuncture, Osteopathy and Chiropractic.
- Hospital Out-patient Statutory Charge.

Only original receipts containing details of the patient's name and date of visit are acceptable for GP Visits.

Benefit

Please see current schedule of benefits for details.

For minor surgery carried out by a GP (warts removal, stitching etc.) the procedure must be stated by the GP on the account. If the bill is submitted unpaid to the fund office, the doctor will be paid immediately less withholding tax. Where the member pays the doctor direct, the receipt should be submitted with a General Claim Form.

MPF

ESB Staff Medical Provident Fund

P.O. Box 384, Rosbrien, Limerick.

The fund office will be pleased to give you further information and advice on any claim.

Please do not hesitate to contact us at:

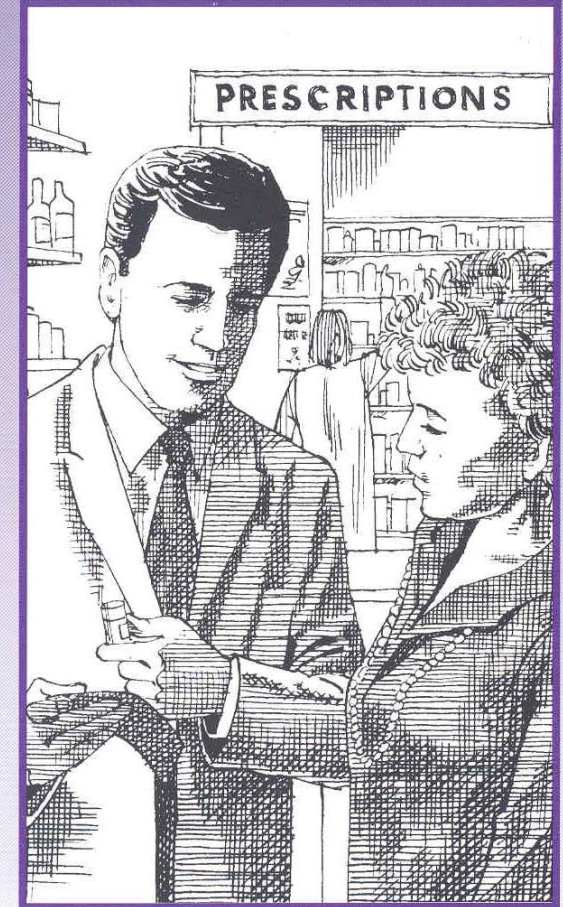
Phone: 061-430 581 / 061-430 523 / 061-430 411

Fax: 061-430 500

Stockcode: 9806563

MPF

G.P. FEES/PHARMACY ANNUAL CLAIM FORM



ELECTRICITY SUPPLY BOARD
BORD SOLÁTHAIR AN LEICTREACHAIS



ESB Staff Medical Provident Fund

ANNUAL G.P. FEES/ PHARMACY CLAIM FORM

For office use only

							Z	Z
--	--	--	--	--	--	--	---	---

Membership Details

Members Name: _____ Staff no: _____
 Location: _____ Tel no: _____

Claim for year ended 31st December, _____

Family Claim
 Single Claim (Please tick appropriate box)

Month	G.P.'s Fees	Prescribed Pharmacy	Hospital O.P. Stat. Charge	Chiropractic	Osteopathy	Acupuncture	For Office Use	Total for Month
January								
February								
March								
April								
May								
June								
July								
August								
September								
October								
November								
December								
Sub Total							Total Cost	
							Less Excess Amount	
							Net Cost	
Members signature _____ Date _____							Net Payment	

Amount for Payment	Claim Created	Claim Verified	Payment Approved