# EU DIRECTIVE APPLICATION FORM
# Post treatment legacy applications (EU Exit)

This application form is for patients who are resident in England and who accessed treatment in the EU, Norway, Iceland or Liechtenstein before 1 January 2021.

You must meet the eligibility criteria that was in place until 31 December 2020. This means that for any applications received after 1 January 2021, where the treatment is on the "specialised" commissioning list, the application will not be progressed.

Find out more by searching for 'EU directive' on www.nhs.uk.

Please read the EU Directive supporting guidance notes to help you complete this application form.

## Part 1: EU Directive Funding Route

☐ I am applying **after** receiving treatment in an EU/EEA country.

☐ The treatment took place **before 1.1.21.**

☐ The treatment was not classified as "specialised" and did not require Prior Approval.

Treatment took place in the following country: _____

**On what basis is the treatment being provided?**

☐ Private healthcare system **or** ☐ State healthcare system

**Is the application in relation to emergency / urgent (unplanned) treatment abroad in the State sector? ☐ Yes ☐ No**

**a)** If Yes, did you have an EHIC / PRC? **☐ Yes ☐ No**

**b)** If Yes, did you claim from the NHS BSA? **☐ Yes ☐ No**

**c)** If Yes, your application cannot be progressed unless evidence is provided that the NHS BSA could not reimburse you under the EHIC / PRC scheme.

Evidence provided: **☐ Yes ☐ No**

## 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** | | | | | | | | | | | |

**Confirm, by ticking the box, that the patient is ordinarily resident in England (living lawfully, on a settled basis), and entitled to receive NHS services:** ☐

**Address for Permanent / settled address in England** *(inc. postcode) for correspondence*

**Are you currently residing at the settled address you have provided above?** ☐ **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 in England (e.g. work, study, health, other)?

_____

**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)**

**NHS treatment**: Please confirm if you are currently being treated on the NHS for the medical diagnosis and / or treatment plan relevant to this application: ☐ **Yes** ☐ **No**

**If YES – provide further details:**

**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: Treating Clinician / Provider Details

**Provide details of the main establishment(s) in the country, where you were 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 4: Treatment details | |
|---|---|
| **a)** | **What is the DIAGNOSED medical condition for which you have received treatment(s) abroad?** |
| | |
| **b)** | **Describe the TREATMENT(S) you have received abroad.** |
| | |

| c) | Record the specific DATE(S) for all the treatment(s) received abroad? *(complete where applicable)* | | | | Receipt no. (Cross reference to Section 5 |
|---|---|---|---|---|---|
| **In-patient stays** (i.e. overnight stays in hospital) | | | | | |
| **Day case appointments** (e.g. day case surgery) | | | | | |
| **Out-patient appointments** (e.g. clinics / consultations) | | | | | |
| **Other appointments** (e.g. physio) | | | | | |
| **Diagnostics tests** (e.g. Blood tests / scans) | | | | | |
| **Equipment / Appliances** (e.g. walking /hearing aids) | | | | | |
| **Drugs / Medication paid for separately**<br><br>Continue on a separate sheet if required | *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** | | | | | |

## Part 5: 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 4c 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) | | | | | |
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| | | | | | |
| | | | | | |
| Please continue on an additional sheet if you need more space and tick here ☐ | | | TOTAL CLAIMED | | |

## Part 6: Supporting further relevant information (to application)

## 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 and Social Care (DHSC), NHS BSA, NHS Counter Fraud Authority 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 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 8 of this form to make this application on my behalf (if applicable).

| | | | |
|---|---|---|---|
| **Name of patient** | | | |
| **Signature of patient** | | **Date** | |

## Part 8: 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

**(Please complete and submit this section with your form)**

| Tick | Documents required to support application form |
|---|---|
| ☐ | **If your treatment was emergency / urgent in the state sector and you claimed via the EHIC / PRC scheme, evidence that the claim was not granted by the NHS BSA.** |
| ☐ | **Proof of residency documents for your permanent / settled address in England, covering dates both before and after treatment.** |
| ☐ | **Treating Clinician's letter / report supporting diagnosis and medical need for treatment and confirmation that treatment took place e.g. discharge summary** *(original copy and English translation required).* |
| ☐ | **Invoices and receipts / proof of payment, for items included in Part 5** *(plus translation(s).* |
| ☐ | **Evidence of exemption for relevant patient charges.** |
| ☐ | **All sections of the application form have been fully completed.** |
| ☐ | **All signatures provided on application form** *(patient / applicant).* |
| ☐ | **Security Question and Answer: Q:** _____<br>*(for phone call ID verification)* **A:**_____ |

**UK Disclaimer:**

UK nationals living in, working in, or visiting the EU may find that their access to healthcare in EU/EFTA States changed when the UK left the EU. This application form relates to a legacy arrangement whereby funding can be applied for, post treatment, if the treatment took place before 1.1.21 and the EU Directive funding criteria were met. Future arrangements will depend on negotiations or decisions by individual countries. You can find out more on the NHS website at www.nhs.uk by searching for 'healthcare abroad'.

**Signature of applicant confirming you have read and understood the above disclaimer:**

**Signature:**_____ **Date:** _____

- Where possible, please send your application and supporting documentation by email to: england.europeanhealthcare@nhs.net.
- Please email your documents as a PDF attachment, do not email embedded documents or photographs of documents. Also organise documents into one PDF for each "category" (e.g. application form, proof of residence, medical documentation in 3 separate PDFs). This will enable your application to be assessed more quickly.

Paper documents should be sent to the following address:

**European Cross Border Healthcare Team**
**NHS England**
**County Hall**
**Leicester Road**
**Glenfield**
**Leicester LE3 8RA**

*Or email:* england.europeanhealthcare@nhs.net
*Or 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.