

ASK YOUR VET TO COMPLETE THESE THREE SECTIONS

6. Vet to complete
GENERAL INFORMATION

When was this pet first registered at your practice? / / /

If this pet has been referred please give the name, address and telephone number of the practice which referred it

Name _____

Address _____

Telephone no _____

In connection with treatment claimed did you:

Make a **house visit**? Yes No

Or provide **out of hours treatment**? Yes No

If **Yes**, why was the house visit/out of hours treatment necessary?

Is any part of this claim for a condition the pet can be vaccinated against? Yes No

If **Yes**, were the pet's **vaccinations** up to date at time of treatment?

Yes Please give date of last vaccination / / / No Don't know

Is any part of this claim for **dental treatment**? Yes No

If **Yes**, was this caused by an injury?

If the claim involves physiotherapy, osteopathy, hydrotherapy or chiropractic manipulation, how many sessions did you recommend? No. of sessions _____

7. Vet to complete
ABOUT THE ILLNESS OR INJURY

Name of the illness or injury (if no diagnosis has been made please give clinical signs) A

Is this condition a continuation? Yes No

Treatment dates: from / / to / /

Did **death or euthanasia** result from this illness or injury? Yes No

Date of death / /

If the pet was put to sleep, did you recommend this? Yes No

When did this illness or injury begin? / / /

(as noted on your records)

To your knowledge has this pet been seen before for:

This illness or injury? Yes No

Any similar or related illness or injury? Yes No

Any similar or related clinical sign(s)? Yes No

If **Yes**, please provide the history with dates

_____ Date / /

_____ Date / /

_____ Date / /

Total amount claimed (inc VAT) £ - A

PLEASE ENCLOSE FULL INVOICES TO SUPPORT THIS CLAIM

8. Vet to complete
DECLARATION BY THE VETERINARY PRACTICE
A

This practice accepts claims paid direct Yes No

By signing this form I confirm I have checked the information on this claim form and it is all correct to the best of my knowledge.

Name _____

Position in practice _____

Email address _____

Vet stamp

Signature _____

Date / /

INCOMPLETE CLAIM FORMS WILL BE RETURNED TO THE POLICY HOLDER AND THIS WILL DELAY YOUR CLAIM

