DEPARTMENT OF SOCIAL PROTECTION

CLAIM FORM FOR **MA1**
MEDICAL APPLIANCE BENEFIT

- **Please answer all questions fully and place a tick (√) in the appropriate boxes.**

PART 1 Details about Yourself

Please state your:
PERSONAL PUBLIC SERVICE NUMBER
(PPS No.) same as RSI/TAX NUMBER

Figures							*Letter(s)*	

Old Insurance Number
(If you worked before 1979)

Full Name _____

Address _____

_____

_____

Birth Surname _____

Date of Birth	*DAY*	*MONTH*	*YEAR*

Mother's Birth Surname _____

Telephone Number _____

Are you: **Single** ☐ **Married** ☐ **Other** ☐

Are you in paid Employment? **YES** ☐ **NO** ☐

If "YES" state present
Employer's Name and Address _____

_____

If "NO" state
Date you last worked _____

If you are claiming any weekly Social Welfare/Health Board Payment, state:

Type of Payment _____

Claim Number _____

If you attended College in the last 2 years state dates:

	MONTH	*YEAR*		*MONTH*	*YEAR*
FROM			TO		

PART 2 Details about your claim

If your Claim for:

(A) MEDICAL APPLIANCES ☐

(B) REPAIRS ☐

If for Medical Appliance, please complete **PART A and PART B**

If for Repairs, please complete **PART B ONLY**

PART A

What type of Appliance do you require?

_____

Have you previously had an Appliance of this kind? **YES** ☐ **NO** ☐

If "YES" please state reason for new Aid(s):

OLD APPLIANCE NO LONGER SUITABLE ☐

LOST/STOLEN/BROKEN ☐

If **Lost/Stolen/Broken** do you have insurance to Cover the Aid(s)? **YES** ☐ **NO** ☐

PART B

I wish to obtain the Appliance from/have repairs carried out by the following Practitioner:

NAME **EGANS HEARWELL LTD**

ADDRESS **5 – 6 LAVITTS QUAY**
CORK

PANEL NO. **6171**

Do you hold a Medical Card? **YES** ☐ **NO** ☐

PART 3 Working in another EU Country

Did you ever work in the United Kingdom or in any other EU Country? **YES** ☐ **NO** ☐

If "YES", state:

The Country: _____

Period of employment in that country:

		MONTH	*YEAR*			*MONTH*	*YEAR*
FROM				TO			
FROM				TO			

PART 4: DECLARATION - You must sign this part

I claim Medical Appliance Benefit and I declare that all the information given is true and complete. I understand that I must not enter into any agreement until I have received written notification from the Department.

SIGNATURE OF CLAIMANT: _____ **DATE:** _____

Data Protection and Freedom of Information

The Department of Social Protection will treat all the information and personal data which you give as confidential. It will only be disclosed to other bodies in accordance with Social Welfare law and it will be subject to the Department's responsibilities under the Data Protection Act and Freedom of Information Act.

Please return this form to:

Treatment Benefit Section,
Department of Social Protection,
Freepost,
St. Oliver Plunkett Road,
Letterkenny,
Co. Donegal
LoCall No. : 1890 400 400 (Ext. 44578)
(Ext. 44521)