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| **GUIDANCE NOTES**  This form can be completedby a person other than the patient, for example by a family member or a clinician. However, all the information provided should be about the patient. (Parts 8 and 9 of this form require the applicant to provide details if they are applying on behalf of the patient.  Please read the guidance available on Scotland’s European Cross-border Healthcare National Contact Point [Contact Point](https://www.nhsinform.scot/care-support-and-rights/health-rights/european-cross-border-healthcare/national-contact-point-for-scotland), and the Scottish Government’s health in Europe webpage <http://www.scotland.gov.uk/Topics/Health/Services/Europe> **and consult NHS Fife’s European Cross-border lead**, Craig Pratt (Assistant Director of Finance), before completing this form.  Telephone 01592 643355 ext 28697 or by email [craig.pratt@nhs.scot](mailto:craig.pratt@nhs.scot)  **The S2 Route:**  Applications must be authorised by your local NHS Board before treatment is provided in another EEA country.   * The treatment must be available and provided by the state healthcare system of the other EEA country * You must have a letter of support from your NHS consultant * It is important to ensure that the EEA country of treatment is prepared to accept an S2 form issued by the UK Government before the treatment takes place. * S2 applications for maternity services must be made directly to the Department for Work and Pensions [overseas.healthcare@dwp.gsi.gov.uk](mailto:overseas.healthcare@dwp.gsi.gov.uk) * require prior authorisation and must be approved by your local NHS Board before the treatment is carried out. * Treatment received in another EEA country must be carried out by the state health sector in that country.   **Reimbursement:** Onlytreatment costs will be assessed for reimbursement. Translation costs of associated paperwork (if required) will be deducted from the amount to be reimbursed.  **Proof of residence:** You must provide evidence to your local NHS Board that you are resident at the stated address and were / will be resident at that address during the treatment period.  **The NHS Fife contact is** Craig Pratt (Assistant Director of Finance) telephone 01592 643355 ext 28697 or by email [craig.pratt@nhs.scot](mailto:craig.pratt@nhs.scot) | |
| **PART 1 - APPLICATION ROUTE** | |
| **Treatment** | Treatment must be by provided by a **State** healthcare provider |
|  | Application must be **before** receiving treatment in another EEA country. |
| **Application Route** | 🞏 I want to apply for funding via the **S2 route** (prior to receiving healthcare provided by the state healthcare system in another EEA country). |

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| **Medical Delay** | Are you seeking treatment in another EEA country because of a medical delay for NHS treatment? 🞏 Yes 🞏 No |
|  | If Yes, please provide written evidence that this delay is deemed to be medically unacceptable and has been assessed as such by a clinician employed by the NHS in the UK. |

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| **PART 2 - PATIENT DETAILS** | | | |
| **Family Name** |  | **First Name(s)** |  |
| **Date of Birth** |  | **Sex** |  |
| **Telephone Contact Number** |  | **Email Address** |  |
| **NHS Number** |  | | |
| **National Insurance Number** |  | | |
| **Permanent address in Scotland** (inc. postcode) | | | |
| **Alternative address in Scotland** (if applicable) | | | |
| **GP Name / Registered GP practice** | | | |
| **GP address** (inc. postcode) | | | |
| **GP telephone number** | | | |

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| **PART 3 - TREATMENT DETAILS IN RELATION TO THIS APPLICATION** | | | | | | | | |
| **1** | **What is the diagnosed medical condition for which you are planning to receive treatment(s) in another EEA country?** | | | | | | | |
|  |  | | | | | | | |
| **2** | **Describe the treatment(s) you are planning to receive in another EEA country.** | | | | | | | |
|  |  | | | | | | | |
| **3** | **Is a clinician’s letter / report attached 🞏 Yes 🞏 No** | | | | | | | |
|  | A letter / report must be attached from your clinician, describing your condition / diagnosis, and confirming the medical need for the treatment(s), together with the evidence base for what will be carried out. The letter / report must clearly state why the treatment is needed.  The letter / report must be from a consultant employed by the NHS in the UK and must support the treatment(s) being carried out in the proposed EEA country. | | | | | | | |
| **4** | **What are the specific dates (if known) for the treatments in another EEA country?** | | | | | | | |
|  |  | | |  | | | | |
| **5** | **What are the estimated costs of the treatment(s)?** | | | | | | | |
| **6** | **What treatments (if any) are you already receiving / have received for this condition. If applicable, please indicate if this is or was or is on the NHS.** | | | | | | |
|  |  | | | | | | |
| **7** | **Have you applied for funding from the NHS previously for this treatment?** | | | | | | |
|  | Applied for funding: **🞏 Yes 🞏 No**  Funding approved **🞏 Yes 🞏 No**  If yes, provide further details, including dates. | | | | | | |
| Details:  If No, provide the reason funding was refused | | | | | | |
| **PART 4 - TREATING CLINICIAN / PROVIDER DETAILS** | | | | | | | |
| **8** | **Please provide details of the main establishment(s) where you are going to be treated** (if this involves more than one establishment, please provide details on a separate sheet). | | | | | | |
|  | **Treating Clinician name** | |  | | | | |
|  | **Name of establishment** | |  | | | | |
|  | **Address** | |  | | | | |
|  | **Country** | |  | | | | |
|  | **Telephone Number** | |  | | | | |
|  | **E-mail address** | |  | | | | |
| **9** | **If applicable to your application, are you exempt from NHS dental charges?** | | | |  | | |
| **PART 5 - SUPPORTING INFORMATION**  **(please reference part / question number and continue on a separate sheet if needed)** | | | | | | | |
|  | | | | | | | |
| **PART 6 - PATIENT DECLARATION** | | | | | | | |
| I declare that all the information provided is corrected 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 Scotland, The Scottish Government Health & Wellbeing Directorates, the Department for Work and Pensions and other NHS bodies and external parties, necessary to process and verify this claim and the investigation, prevention, detection and prosecution of fraud.  I understand that the NHS is not liable for healthcare received in another EEA country when funded under S2 arrangements.  **By ticking the following box, I confirm that I am ordinarily resident in Scotland and am entitled to receive NHS treatment and services at no charge 🞏**  I hereby give permission for the person identified as the Applicant in Part 8 of this form to make the application on my behalf (if applicable). | | | | | | | |
| **Name of Patient** | |  | | | | | |
| **Signature of applicant** | |  | | | | **Date** |  |

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| **PART 7 - CONFIRMATION OF THE APPLICANT** | |
| **Are you (the patient) also the applicant** | **🞏 Yes 🞏 No**  **If No, please complete Parts 8 and 9** |

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| **PART 8 - DECLARATION BY 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 9 - DETAILS OF THE APPLICANT** | | | | | | |
| **Family name** | |  | | **First Name(s)** |  | |
| **Relations to patient** | |  | | **Title** |  | |
| **Telephone number** | |  | | **E-mail address** |  | |
| **Applicant’s Address (for correspondence)** | |  | | | | |
| **Please note that even if you are acting on behalf of the patient, proof of the patient’s identity, as per the guidance notes, must still be provided. Parents acting on behalf of their children are required to submit of their own residence at the address given above.** | | | | | | |
| **PART 10 - APPLICATION CHECK LIST (YOU MUST COMPLETE THIS SECTION PRIOR TO SUBMITTING YOUR FORM** | | | | | | |
|  | **1. 🞏 Proof of residence is attached (Copy of passport or national identity card AND copy of one of the following: utility bill / council tax bill / tenancy agreement / wage slip – no more than 3 months old).**  **2. 🞏 Clinician’s letter attached (in English or certified translation required).**  **3. 🞏 All sections of application form completed.**  **4. 🞏 Signatures where required.** | | | | | |

Please send your completed form and accompanying documents to your local NHS Board. Addresses and contact details are available from the Scotland’s European Cross-border Healthcare National Contact point at:

[**http://www.nhsinform.co.uk/Rights/Europe/ContactsInScotland/NHS**](http://www.nhsinform.co.uk/Rights/Europe/ContactsInScotland/NHS)

**NB It can take up to 20 working days for a fully completed application to be processed and a decision to be made.** **Therefore, if you are applying for prior authorisation, either because it is mandatory or on a voluntary, or you are unsure about the correct route to suit your particular circumstances, you may wish to contact your NHS Board prior to submitting a formal application**.