Neonatal Expenses Fund (NEF) claim form (NEF1): Travel and Subsistence costs for families with babies in neonatal care

NEF is designed to help parents of premature and sick newborn babies to offset the cost of travelling to and from hospital during the early days of their baby's life and the subsistence required to allow them to spend time with their newborn in order to bond as a family during these early days.

Parents are integral to the care of their child whilst in neonatal care in order to establish breastfeeding and secure bonding and to allow parents to build the skills to care for their babies upon discharge from hospital.

What Expenses Can be Claimed

- Transport
- Parking
- Meals and Subsistence

Making a claim

The NEF(1) form is attached, further forms are available from hospital wards, clinics and cash offices or to download at **www.mygov.scot/neonatal-expenses-fund**. The form should be completed by the parent or guardian and signed and certified as detailed on the form. This includes certification of qualification from neonatal nurse or medical professional caring for your baby.

Claims must be submitted within three months of the patient's discharge from hospital.
Claims outside this time will not be considered for reimbursement except in very exceptional circumstances.

On completion the forms must be handed into the cash office within the hospital of attendance for reimbursement.

Full terms and conditions of the fund can be found at
www.mygov.scot/neonatal-expenses-fund/what-you-can-claim-for/

NEF(1) CLAIM FORM

SECTION 1: PERSONAL DETAILS: TO BE COMPLETED BY (OR ON BEHALF OF) CLAIMANT

PATIENT NAME (If baby is unnamed please write Baby's Surname)

PATIENT DATE OF BIRTH D D M M Y Y Y Y

PATIENT DUE DATE D D M M Y Y Y Y

PARENT NAME/S

ADDRESS

POST CODE

CONTACT PHONE NUMBER

BANK DETAILS (only complete if you wish to be paid by Bank Transfer)

NAME(S) OF ACCOUNT HOLDER(S)

BANK/BUILDING SOCIETY NAME

BRANCH SORT CODE

BANK/BUILDING SOCIETY ACCOUNT NUMBER

SECTION 2: PATIENT DETAILS: TO BE COMPLETED BY (OR ON BEHALF OF) CLAIMANT

HOSPITAL ATTENDED

WARD NUMBER/NAME

CONSULTANT NAME

DATE OF ADMISSION: D D M M Y Y Y Y TIME OF ADMISSION:

DATE OF DISCHARGE: D D M M Y Y Y Y TIME OF DISCHARGE:

SECTION 3: AUTHORISATION: TO BE COMPLETED BY HOSPITAL STAFF

I confirm that the patient named above was an inpatient in this hospital on the dates stated in Section 2:

Signature:

Print Name:

Designation:

Date: D D M M Y Y Y Y HOSPITAL STAMP:

SECTION 5: DETAILS OF CLAIM TO BE COMPLETED BY (OR ON BEHALF OF) CLAIMANT

Date	Expenses Type (car/bus/meal)	Details of expense Please indicate whether this is a single or return journey	Mileage	Amount Claimed
EXAMPLE: 01/01/18		RETURN CAR JOURNEY FROM HOME ADDRESS TO HOSPITAL	10	£1.40
		TOTAL		

SECTION 5: DECLARATION AND SIGNATURE BY (OR ON BEHALF OF) CLAIMANT

I certify that I have read and understand the Travel and Subsistence Rules and conditions under which I am claiming these expenses. I confirm that this claim complies with these rules and conditions. I certify that I am the legal parent/ guardian of a child who received neonatal care as outlined in this form and declare that the information I have given on this form is correct and complete and that I have not claimed elsewhere for the expenses detailed on this form.

I understand that if I knowingly provide false information this may result in legal action and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by NHS Scotland and Counter Fraud Services for the purposes of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Signature:

Date: D D M M Y Y Y Y

CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF DISCHARGE FROM HOSPITAL

SECTION 6: FOR OFFICE USE ONLY

I have checked the details of this claim as listed above and hereby authorise payment of £

Signature:

Designation:

Date: D D M M Y Y Y Y