FSS Iardheiscirt HSE South West	**HAIRPIECES APPLICATION FORM**	HD1

Section A should be completed and signed by the patient. Section B should be completed by Prescribing Consultant and/or GP and Provider of Choice. Completed form should then be sent to HSE Community Services, West Cork Local Health Office, Coolnagarrane, Skibbereen, Co. Cork.

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SECTION A: ***To be completed by the patient:***

First Name:																		
Surname:																		
Address:																		

Do you currently have a Medical Card Yes ☐ No ☐

If Yes, Card Number:_____

Expiry Date:_____/_____ PPS No:_____
Month Year

Phone Number:_____

Have you made a claim to Department of Social Protection?

Yes ☐ No ☐ If Yes, please confirm contribution received_____

DATA PROTECTION NOTICE:

• The information on this form will be used by the Health Services Executive to assess the eligibility of the named person for the items listed below.

• The named person may access information relating to themselves only, on prescription claims processed in their name by the HSE

Please note you cannot claim from both schemes (HSE and Department of Social Protection) for the same hairpiece.
The HSE can pay provider of your choice directly for contribution towards cost of a hairpiece up to a maximum of €770.00 in a twelve month period or a refund can be made directly to you.
Please tick appropriate box.

Please pay provider of choice directly* ☐ Please refund me directly** ☐

Signature:		**Date:**	/ /

Day month year

Please note that prior to payment/refund, this application will need to be approved by the HSE. * if you wish to obtain the hairpiece from your provider of choice the company will need to attach a quote with this application form. ** If you have already paid for the hairpiece and wish to receive a refund please attach original receipt; Please note that private health insurance members should first claim through their medical insurers. Completion of Section B is compulsory.

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SECTION B: ***To be completed by the prescribing Consultant/GP or accompanied by Consultant/GP prescription and priced by the Patient's Choice of Provider:***

I hereby certify that .....is under my care for the treatment of …… and requires hairpiece for this condition.

Consultant/GP Signature	**Consultant/GP Stamp**
_____	

Company of Choice Stamp	**Cost**

Hairpiece Provider signature …….. (Invoice to be accompanied with Approval Number from HSE)

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For Office Use Only

Approved/Refused: …….....……Date:…..…/…..…/…..…… Expiry of approval...../...../.....