Out-patient Scans

Approved Treatment Centres

Ref21OCF

Irish Life health

To make sure that you are not out of pocket, Irish Life Health and most treatment centres have a direct payment agreement that enables your claim to be settled directly between the treatment centre and Irish Life Health. To facilitate this, Irish Life Health may provide information to the treatment centre verifying your membership eligibility.

PART 1 - Patient Details This part to be completed by the Patient.

* Patient's name:

* Policy Number: VIV

* Patient's membership number:

Daytime contact number:

Date of Birth (dd/mm/yyyy):

Was treatment received directly as a result of an accident? Yes ☐ No ☐

Did you elect to be a private patient of the consultant? Yes ☐ No ☐

History of Illness Section Please complete this section in full.

When did you first suffer from these symptoms or illness? (dd/mm/yyyy)

When did you first visit your doctor with these symptoms? (dd/mm/yyyy)

Name of doctor first attended:

Contact number of doctor first attended:

Address of doctor first attended:

Have you ever made a claim for this or any other similar condition in the past with Irish Life Health or any other health insurer? Yes ☐ No ☐

If yes, please supply details of where and when:

Personal injury claims This section is for completion in case of personal injury.

Date of occurence of injury (dd/mm/yyyy):

Place of injury:

Name of person, company or public body responsible:

* Do you plan to pursue a claim against a third party? Yes ☐ No ☐

Brief description of how accident / injury occurred:

Name and address of your solicitor (where applicable):

Continued on Page 2

*Mandatory Field

Declaration

I declare that at the time I underwent medical treatment I was a party to a health insurance contract and was entitled to treatment under my Irish Life Health plan. I declare that my doctor, including accident and emergency referral, recommended the treatment and referred me to the appropriate consultant for further treatment. I declare that to the best of my knowledge, the information provided in Part 1 of this form is accurate, true and complete. I authorise the doctors, consultant or hospital to furnish Irish Life Health, or any authorised agent it may appoint to act on its behalf, with any information requested, including access to my hospital/medical records, where this is necessary in relation to treatment or services received by me or my named dependants in respect of this claim. I understand that only medical information relating to my claim will be requested by Irish Life Health. I authorise the direct payment by Irish Life Health to the doctors/consultant/hospital as appropriate for the services set out on this claim form to the extent provided for under my Irish Life Health plan. I verify the details of the accounts submitted on my behalf by the doctor/ hospital/consultant as an accurate reflection of the treatment I received. I understand that the details of these amounts will be included in my Irish Life Health statement of payment and I will have the opportunity to contact Irish Life Health directly with any queries. Charges not covered under the Irish Life Health plan to which I subscribe will remain my responsibility or that of the named dependant who received the treatment to settle directly with the doctors, consultant or hospital concerned. In consideration of Irish Life Health discharging my hospital and medical expenses to the extent of cover limits, I undertake to Irish Life Health to include these expenses as part of my claim (including any future claim) against a third party and to inform my solicitor or Personal Injury Assessment Board of the medical/ hospital expenses and claims made when pursuing any third party claim. In the event that my claim is adjudicated upon, and subject to any order/award to the contrary, I further undertake to repay Irish Life Health the amounts due and owing to them out of the proceeds of any settlement received. In the event that a reduced settlement is made, I undertake to provide Irish Life Health with verification of the award made from my legal representatives and a certificate from counsel, confirming the amounts recovered. I understand and authorise that to process my claim Irish Life Health will seek further information and/or share relevant information with my solicitor, PIAB or other similar source which Irish Life Health deem necessary in relation to the assessment and management of this claim.

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I understand that the information will be used to process the claim as outlined above and for the purposes as set out in the ILH privacy notice which can be found at **http://www.irishlifehealth.ie/privacy-and-legal/privacy-statement/**

* Print name in block capitals:

* Signature:

* Date (dd/mm/yyyy):

*Read all forms carefully and make sure you fill in the mandatory fields

Continued on Page 3

*Mandatory Field

PART 2 This part to be completed in full by attending consultant.

Patient's name:

Please state the name of the person who referred patient to you:

Nature of symptoms:

A Duration of symptoms: day(s) OR week(s) OR month(s) OR year(s)

B Has the patient a history of these or any related symptoms? Yes ☐ No ●

C If yes, please give the details and dates of the treatments prior to this admission:

D Is the admission/treatment related to a clinical research study? Yes ☐ No ●

Procedure details Please supply a full description and details of test/treatment supplied covered by this claim:

Procedure Code: Clinical Indication Code: Units: Contrast/ Perfusion:

* MRI Code 1:

MRI Code 2:

MRI Code 3:

Description of procedures (including anatomical site being examined):

Procedure Code: Clinical Indication Code: Units: Contrast:

* CT Code 1:

CT Code 2:

CT Code 3:

Description of procedures (including anatomical site being examined):

Procedure Code: Clinical Indication Code: Units:

* PET CT Code 1:

PET CT Code 2:

Description of procedures (including anatomical site being examined):

Procedure Code: Clinical Indication Code: Units:

* Nuclear Code 1:

Nuclear Code 2:

Nuclear Code 3:

Continued on Page 4

*Mandatory Field

Description of procedures (including anatomical site being examined):

Clinical interpretation of scan / diagnosis:

Anaesthesia: General: ☐ Monitored: ☐ No anaesthesia: ☐

Reason for anaesthesia:

Declaration

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I understand that the information will be used to process the claim as outlined above and for the purposes as set out in the ILH privacy notice which can be found at **http://www.irishlifehealth.ie/privacy-and-legal/privacy-statement/**

* Print name in block capitals:

* Signature: * Date (dd/mm/yyyy):

Irish Life Health Doctor Code:

Part 3 Treatment Centre Details This part to be completed by the treatment centre

* Name of Treatment Centre:

* Irish Life Health Treatment Centre Code:

* Type of Scan: MRI: ☐ CT: ☐ Pet CT: ☐ Nuclear: ☐ Treatment Centre Stamp:

* Date of Scan (dd/mm/yyyy):

Time of Scan: (hh:mm)

* MRN Number:

* Episode Account Number:

Please attach bills/invoices with relevant procedure code.

Clear Form **Print Form**

*Mandatory Field