Hospital Claim Form

Direct Payment of Medical Charges

Ref19HCF

Irish Life health

To make sure that you are not out of pocket, Irish Life Health and most hospitals have a direct payment agreement that allows your claim to be settled directly between the hospital and Irish Life Health. To facilitate this, Irish Life Health may provide information to the hospital verifying your membership eligibility. All you need to do is complete Part 1 of the claim form and the hospital will submit the claim for you. Failure to complete the claim form correctly may result in the return of the claim in its entirety.

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

Patient's name: Patient's membership number*:

Daytime contact number: Date of Birth: (dd/mm/yy)

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

*This can be found on your membership card and on your membership certificate

History of Illness Section

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

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

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:

Accident / Injury Details

This section is for completion in the case of Accident / Injury

Date of Accident / Injury (dd.mm.yy): (dd/mm/yy) Place of accident / injury:

Brief description of how accident / injury occurred:

Name of person, company or public body responsible:

Do you plan to pursue a claim against a third party? ◯ Yes ◯ No Name and address of your solicitor (where applicable):

Consent

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.

Declaration

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/ we have given on this form for the purposes set out in the Irish Life Health 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/yy)

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PART 2 This part to be completed in full by the Admitting Doctor/Consultant/GP.

Patient's full name:

Are you the admitting consultant? ◯ Yes ◯ No If no, please state name of admitting consultant:

Name of the person who referred the patient to you:

Was the admission: ◯ Emergency ◯ Planned Was this a re-admission for the same condition? ◯ Yes ◯ No

Nature of symptoms:

A When did the patient first become aware of symptoms? Start date (dd/mm/yy)

B Is the admission/treatment related to a clinical research study? ◯ Yes ◯ No

When did the patient first consult you with these symptoms? (dd/mm/yy)

Reason for admission (admitting diagnosis):

Please supply full description and details of tests/treatment supplied covered by this claim:

Procedure Code 1:	ICD Code:	Date of Procedure: (dd/mm/yy)
Procedure Code 2:	ICD Code:	Date of Procedure: (dd/mm/yy)
Procedure Code 3:	ICD Code:	Date of Procedure: (dd/mm/yy)

Type of anaesthesia administered: ◯ General ◯ Monitored ◯ Regional ◯ Epidural ◯ No anaesthesia

In non surgical cases please list medical treatment offered and description:

Did the patient require ICU services? ◯ Yes ◯ No If yes, please complete the ICU supplement form.

Please confirm the IV therapy administered to the patient.

Name of IV Therapy:	Start Date: (dd/mm/yy)	End Date: (dd/mm/yy)
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Did you request attending consultant services? ◯ Yes ◯ No If yes, please provide details:

Was the patient transferred from the hospital during this visit for any other investigations? ◯ Yes ◯ No

If yes, please supply the name of the hospital and nature of test/treatment performed:

Are there any circumstances or additional reasons that led to a delayed discharge during this admission? ◯ Yes ◯ No

If yes, please provide details:

Discharge Status

◯ Home ◯ Still in hospital

◯ Transfer to another hospital Please specify the name of the hospital:

◯ Long Term Care / Nursing Home Please specify the name of the nursing / convalescence home:

◯ Deceased

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Signature: Date: (dd/mm/yy)

Print Name: Irish Life Health Doctor Code:

PART 3 - Hospital Details This part to be completed in full by the Hospital.

Name of hospital/place of treatment:

Date of admission: (dd/mm/yy)

Date of discharge: (dd/mm/yy)

Time of admission: (hh.mm)

Time of discharge: (hh.mm)

Room Type	Please tick	Ward/Room Name/No.	Bed No.	No. days in each bed
Private room	☐			
Semi-private room	☐			
Public room	☐			
Day bed	☐			
Side room	☐			
NICU/ICU/HDU/CCU	☐			

Total number of days the patient did not occupy the above bed(s) during this admission:

Hospital stamp:

Hospital code:

Please attach bill with relevant procedure code.

Clear Print

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