Irish Life health

Overseas Pre-approval Form

Application for surgical treatment overseas. For elective treatment or treatment not available in Ireland.

Note: All surgical treatment overseas must be pre-approved in advance of travel.

Part 1 and Part 2 of this form (including the consent below) must be completed by the Patient or Policy Holder who is applying for surgical treatment overseas. Part 3 must be completed by the referring Doctor/Consultant in Ireland.

For Office Use Only

Claim no:

PART 1 This part to be completed by the Patient and/or the Policy Holder.

Patient's name:

Patient's membership number:*

Daytime contact number or mobile of patient:

Patient's date of birth (dd·mm·yy):

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

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

History of Illness Section

Please complete this section in full.

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 and address of doctor first attended:

Telephone number 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:

PART 2 This part to be completed by the Patient and/or the Policy Holder.

Name of overseas Hospital/Place of Treatment:

Full address of overseas Hospital/Place of Treatment:

Telephone number of overseas Hospital/Place of Treatment:

Email of overseas Hospital/Place of Treatment:

Contact name at overseas Hospital/Place of Treatment:

Actual or expected date of admission (dd·mm·yy):

Actual or expected date of discharge (dd·mm·yy):

Expected hospital costs?

Expected Consultant costs?

Declaration

I declare that at the time I applied for overseas 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 recommended the treatment (including accident and emergency referral) 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. This includes access to my hospital/medical records, where 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 understand that charges incurred for overseas treatment 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 against a third party and to inform my solicitor or Personal Injury Assessment Board to this effect when pursuing any 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/**

Your signature:

Date:

Please turn over

PART 3 This part to be completed in full by the Referring Doctor/Consultant

Note: Referring Doctor/Consultant must hold a current full registration with the Irish Medical Council

Consultant and medical section

Patient's Full Name:

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

Nature of symptoms:

A Duration of symptoms (dd·mm·yy): ☐☐·☐☐·☐☐

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:

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

Is this treatment related to a clinical research study? Yes ☐ No ☐

History of treatment to date:

Primary diagnosis:

Secondary diagnosis:

Proposed Procedure Code 1: ☐☐☐☐☐ ICD Code: ☐☐☐☐☐ Proposed Date of Procedure: (dd·mm·yy): ☐☐·☐☐·☐☐

Proposed Procedure Code 2: ☐☐☐☐☐ ICD Code: ☐☐☐☐☐ Proposed Date of Procedure: (dd·mm·yy): ☐☐·☐☐·☐☐

Proposed Procedure Code 3: ☐☐☐☐☐ ICD Code: ☐☐☐☐☐ Proposed Date of Procedure: (dd·mm·yy): ☐☐·☐☐·☐☐

Please supply full description and details of surgical treatment to be performed:

How will the patient be transported to and from the hospital during this visit?

What is the expected outcome of the proposed surgical treatment?

What is the expected length of stay in hospital?

Is any further treatment required? Yes ☐ No ☐

If yes, please supply outline of details:

Will the patient be discharged to a place of convalescence?

If yes, please supply details:

Consultant Name (Block capitals):

Qualifications:

Consultant Email/Tel:

I hereby declare that the proposed treatment described above is medically necessary and appropriate for the patient's medical condition, as described on this form:

Consultant signature: Date:

Please turn over

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