Irish Life health

Post-Natal Home Help Form

Member Details

Member name	
Irish Life Health Membership Number	
Member address	
Child(ren) name(s)	
Date of birth of child(ren)	
Hospital/Place of birth	

Claim

Service provided	Date of service	Hours Worked
Total claimed		

Signed by service provider	
Irish Life Health member comments:	
Validated by Irish Life Health member:	

For Office Use Only	
Service Provider Name	
Service Provider Number	
Service Provider Telephone number	

Irish Life health

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/

Signature (member)							
Date:							

Print Clear