

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: This part to be completed by the Patient and/or the Policy Holder

Patient's full name												
Daytime contact number or mobile of patient												
Patient's membership number												
Patient's date of birth (dd.mm.yy)												

## Personal injury claims

This section is for completion in the case of personal injury

Date of occurrence of injury (dd.mm.yy)												
Place of injury												
Do you plan to pursue a claim against a third party?											YES	NO
Brief description of how injury occurred												

## Third party claims claims

This section is for completion where you are making a claim against a third party (another person, company or public body, or where another person was responsible for your injury).

Name and address of person, company or public body responsible												
Name of insurance company												
Name of solicitor												
PIAB contact name												
Solicitor contact number												

### 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 to the best of my knowledge, the information provided in Part 1 of this form is accurate, true and complete. I authorise the doctors or minor injury clinic 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 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/minor injury clinic 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 minor injury clinic concerned.

### 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>.

<b>Signature</b>	<b>Date</b>
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### PART 2: This part to be completed in full by the attending doctor

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

Procedure Code 1						ICD 10 Code				Date of procedure (dd.mm.yy)				
Procedure Code 2						ICD 10 Code				Date of procedure (dd.mm.yy)				

Discharge status	Home	Transfer to hospital
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### DECLARATION by Minor Injury Clinic staff

I hereby declare that the treatment I am claiming for was medically necessary and was appropriate for the patient's medical condition as described above.

<b>Signature</b>	<b>Date</b>
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Name of Minor Injury Clinic
Minor Injury Clinic code: