Irish Life health

Gender Reassignment Procedures Pre-authorisation Form

Application for gender reassignment surgical treatment(s).

Note: All surgical treatment must be pre-approved in advance of hospital admission or 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.
Part 3 must be completed by the referring Consultant in Ireland.

For Office Use Only

Claim no: ☐☐☐☐☐☐☐

PART 1 This part to be completed by the Patient

Patient's name as it appears on the policy:

Patient's preferred name:

Patient's membership number:* Patient's date of birth: (dd.mm.yy)

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

History of condition

Please complete this section in full.

When were you first diagnosed with gender dysphoria? (dd.mm.yy)

When did you first visit your doctor regarding gender dysphoria?: (dd.mm.yy)

GP name:

Endocrinologist name:

Psychiatrist name:

Surgeon name:

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

Name of Hospital/Place of Treatment:

Full address of Hospital/Place of Treatment:

Telephone number of Hospital/Place of Treatment:

Email of Hospital/Place of Treatment:

Contact name at Hospital/Place of Treatment:

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

Consent

I declare that at the time I applied for 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 and referred me to the appropriate consultant(s) 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(s) 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 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 treatment will remain my responsibility to settle directly with the doctors, consultant or hospital concerned.

Declaration

I confirm that all the details, answers and information given in this form are true, accurate and complete. I confirm that I am giving my permission to you to use the information I 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/

Your Signature Date: (dd.mm.yy)

Please turn over

PART 2 This part to be completed in full by the Referring Consultant.

Notes: Referring Consultant must hold a current full registration with the Irish Medical Council
Full biological and psycho-sociological reports should accompany this pre-authorisation form.

Consultant and medical section

Patient's full name:

Patient's preferred name:

Description of presenting condition:

A Duration of condition:

B Name of Psychiatrist:

Date of first visit: (dd.mm.yy) Number of consultations or visits?

Treatment and/or medication prescribed?

Name of Endocrinologist:

Date of first visit: (dd.mm.yy) Number of consultations or visits?

Treatment and/or medication prescribed?

C Does the patient have real life experience living as their chosen gender? Yes ☐ No ☐

Please provide details and dates:

Dates: (dd.mm.yy) to (dd.mm.yy)

When did patient first consult you with the condition? (dd.mm.yy)

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

Please provide details:

Any other treatment or surgery in addition to the above:

Primary procedure to be performed:

Secondary procedure to be performed:

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:

What is the expected length of stay in hospital?

Is any further treatment required? Yes ☐ No ☐ If yes, please supply details:

Will the patient be discharged to a place of convalescence? Yes ☐ No ☐ If yes, please supply details:

Consultant Name (Block capitals):

Consultant Email/Tel: Consultant MCRN:

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

Consultant signature: Date: (dd.mm.yy)

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