Application for the proposal of new procedure/therapy, drug or new facility for consideration by Irish Life Health

In order to allow us review your proposal please ensure the following steps are completed.

Section 1 to be completed for procedure / Therapy or drug.

Section 2 to be completed for a new facility.

- Where a proposal is for both a new procedure /Therapy or drug AND a new facility all sections must be completed.
- Please complete all parts in full (typed preferably).
- Please ensure it is accompanied by relevant scientific papers e.g. RCT findings, Systematic reviews, Health Technology Assessments

If making reference to an Irish Life Health member, or any other patient currently under your care, please ensure no personal detail relating to that member/patient is provided in this form.

Personal Details

Submitting Consultant/Facility:	
Associated Clinic/ Hospital/ Setting:	
Specialty:	
Medical Council Number:	
Contact information:	
Phone number:	
Email address:	

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Section 1 – Procedure/ Therapy/ Drug Proposal

Please complete this section if your proposal is in relation to a new and/or additional procedure/ therapy/ drug.

Part 1 – General Information

Please provide a description of proposed new procedure/therapy/drug:

Please provide a detailed account of how the procedure/therapy/drug is carried out/administered:

Is there currently a similar service on the Irish Life Health's Schedule of Benefits? If yes, please provide details including the Schedule of Benefits code if applicable:

Please provide details on the purpose/ clinical necessity for this new procedure/ therapy/ drug:

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Please advise location of where the proposed procedure/ therapy/ drug will be administered:

Please provide evidence to support that this facility is an approved centre for this proposed procedure/ therapy/ drug? (Availability of expertise, resource and so on):

Is this procedure/therapy/ drug currently available in:

Public Hospital/ Facility:	Yes ◯	No ◯
If yes, please provide more information:		

Private Hospital/ Facility:	Yes ◯	No ◯
If yes, please provide more information:		

Section 1

Part 2 – Clinical Effectiveness Appraisal

If a new procedure/ therapy/ drug is being proposed, please outline the current stage of development?

Please provide details of research-based evidence and proven outcomes to support your proposal (add appendices if necessary):

Please outline, in detail, patient selection criteria for this proposed procedure/therapy/drug considering available standards, guidelines and contraindications:

Please provide details on expected volumes for this procedure/ therapy/ drug, taking into account yearly projections and other similar offerings available to patients:

The proportion of Irish Life Health members who may avail of this procedure / therapy/ drug:

What is the intended destination for this procedure/ therapy/ drug administration: (Please Tick)

Consultant Private Rooms: ◯	Out-Patient: ◯	GP Practice: ◯
Day Care: ◯	Non-Hospital Facility: ◯	In-Patient: ◯
If in-patient, please advise on the expected length of stay according to current care guidelines. Expand on potential recovery hurdles that may need to be met prior to discharge:		

Will the procedure require any of the following:

General Anaesthetic:	Yes ◯	No ◯
Monitored Anaesthetic:	Yes ◯	No ◯
Sedation:	Yes ◯	No ◯
Regional Anaesthetic:	Yes ◯	No ◯
Other (please provide detail)		

Please provide any additional information relevant to the provision of this proposed procedure/therapy/drug not already included which may need to be considered:

Please outline how staff training will be carried out/ delivered and maintained:

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Section 1

Part 3 – Financial/ Economic Evaluation

Please provide a detailed breakdown of both direct and in-direct costs associated with this proposed procedure/ therapy/ drug:

Please provide details on the cost of fees including explanation of charges:

A. Professional fee details:

B. Technical fee details:

NOTE: Unit costs will be the subject of negotiation and agreement upon approval of this procedure/ therapy/ drug

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Please provide any additional information relevant to this proposal that has not been included in Parts 1, 2 or 3:

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 (requesting Consultant)	
Date:	

Date: Please be advised that this is an approval request form only.

Consultants/Hospitals will be advised formally by Irish Life Health if the procedure/therapy is approved for inclusion in the Schedule of Benefits.

Section 2 – Facility Proposal

Please complete this section if your proposal is in relation to a new and/or additional facility
Please note Irish Life Health reserve the right to carry out a site visit of the facility prior to approval

Part 1 – Company Details

Please provide the following in relation to the proposed facility

Company name:	
Company address:	
Contact name:	
Registered company of ownership:	

Please provide the names and occupations of the directors. Please also include the percentage shareholding of each director:

Section2

Part 2 – General information

Please provide a description of the facility, its intended purpose and the current stage of development:

Please outline the necessity for this service at this location and describe the current access difficulties experienced by patients:

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Please provide an outline of this facility under the following:

Number of clinical and non-clinical rooms:	
Number of private and semi-private rooms:	
Number of day beds:	
Catering facilities:	
Waiting areas:	
Bathroom facilities:	
Mobility accessibility areas (wheelchair, handrails etc):	
Regulatory compliance (fire, evacuation etc):	

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Section 2

Part 3 – Clinical Services

Please outline what medical and/ or clinical services will be provided at this facility:

Please outline the associated cost of these services as well as plans for further development within the facility:

Are the procedures/ therapies which will be carried out in your facility currently available in:

Public Hospital/ Facilities:	Yes ◯	No ◯
If yes, please provide more information:		

Private Hospital/ Facility:	Yes ◯	No ◯
If yes, please provide more information:		

Please give a breakdown of the following:

Estimated throughput of patients who will be seen in this facility along with the projected growth for the next three years:
The proportion of Irish Life Health members who may be treated at this facility:

Please state the external professional and clinical standards that are/ will be in place:

Section 2

Part 4 – Financial/ Economic Evaluation

Please state the estimated unit cost per intervention and a basis for this estimation:

Please provide a list of all charges and a basis for these charges:

Please provide any other estimated associated costs and/ or future development plans:

Please outline any envisaged expense reduction/ cost savings (reduced length of stay etc):

How will this facility enhance the benefits offered to our members whilst protecting their premium?

If so, how will this proposed facility provide added benefits to Irish Life Health members in a fashion that would justify any increase in premiums necessary to pay for it?

Section 2

Part 5 – Staffing Evaluation

State the number of full- and part-time staff in each of the following categories. Please provide the qualifications, grades and titles where applicable:

		Number of	Qualifications/Titles/Grades (Where applicable)
A.	Consultants		
B.	Nurses		
C.	Clinical/ Allied		
D.	Supporting Staff		
E.	Other		

Please outline how staff training will be carried out/ delivered and maintained:

Please outline how the responsibility and implementation of quality standards and quality control will be handled:

Section 2

Part 6 – Funding

How is this facility and/ or equipment being funded (leased, purchased or other methods)? Please include rates and term if applicable:

Capital Costs

What is the total capital cost required for the service? Please breakdown as follows:

A. Building Costs and Maintenance
B. Equipment Purchase Price including handling/ Replacement/ Upgrade/ Shipping and Installation costs

C. Training Costs

D. Cost of any Special Unit and/ or Modifications required to Existing Physical Environment – Please provide details

E. Grants:

Please provide any additional information relevant to this proposal that has not been included in Section 2 Parts 1-6:

Declaration

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Signature (requesting Consultant)	
Date:	

Date: Please be advised that this is an approval request form only.

Consultants/Hospitals will be advised formally by Irish Life Health if the procedure/therapy is approved for inclusion in the Schedule of Benefits.

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Appendix 1

Please complete and submit with Request/ Proposal

Expenditure - Pay	Current Year (Year 0)	Projection for Year 0+1	Projection for Year 0+2	Projection for Year 0+3
Medical (incl. fees)				
Nursing & Allied				
Catering & Housekeeping				
Administration				
Pensions & Benefits				
Other (incl. Directors, remuneration & Consultancy Fees)				
CSR				
TOTAL PAY				

Expenditure – Non Pay	Current Year (Year 0)	Projection for Year 0+1	Projection for Year 0+2	Projection for Year 0+3
Drugs & Medicines				
Medical & Surgical Supplies				
Catering/ Provisions				
Utilities				
General Supplies				
Repairs & Maintenance				
Waste Management				
Insurance, Audit & Legal Fees				
TOTAL NON PAY				