Irish Life health

# Psychiatric Hospital Claim Form

## Direct Payment of Medical Charges

To make sure that you are not out of pocket, Irish Life Health and most hospitals have a direct payment agreement that enables your claim to be settled directly between the hospital and Irish Life Health. To facilitate this, Irish Life Health may provide information to the hospital verifying your membership eligibility. All you need to do is complete Part 1 of the claim form and the hospital will submit the claim for you. If you have an out-patient claim, please call 01 5625100. Failure to complete the claim form correctly may result in the return of the claim in its entirety.

### **PART 1 - Patient Details** This part to be completed by the Patient and/or the Policy Holder

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient's full name: | | | | | | | | | | | |
| Patient's membership number: | | | | | | | | | | | |
| Patient's date of birth: (dd/mm/yy) | | | | | | | | | | | |
| Daytime contact number: | | | | | | | | | | | |
| Was treatment received directly as a result of an accident? (Please tick) | | | | | | | | Yes | ◯ | No | ◯ |
| Did you elect to be a private patient of the consultant? (Please tick) | | | | | | | | Yes | ◯ | No | ◯ |

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

### History of Illness Section

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 of doctor first attended: | | | | | | | | | | | |
| Contact number of doctor first attended: | | | | | | | | | | | |
| Address 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: | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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### Third party 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 of insurance company: | |
| PIAB contact name: | |
| Name of solicitor: | |
| Contact number of solicitor: | |

## Declaration

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 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/

| | |
|---|---|
| Print name in block capitals: | |
| Signature: | |
| Date: (dd/mm/yy) | |

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**Part 2:** This part to be completed in full by the Admitting Doctor/Consultant/GP.

| | | | | |
|---|---|---|---|---|
| Patient's full name: | | | | |
| Are you the admitting consultant? | Yes ◯ | No ◯ | | |
| If no, please state name of admitting consultant: | | | | |
| Name of the person who referred the patient to you: | | | | |
| Was the admission: | Planned ◯ | Emergency ◯ | | |
| Was this a re-admission for the same condition? | Yes ◯ | No ◯ | | |
| Nature of symptoms: | | | | |
| | | | | |
| A When did the patient first become aware of symptoms? | | | | |
| 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 admission: | | | | |
| | | | | |
| | | | | |
| When did the patient first consult you with these symptoms? | | | | |
| Reason for admission (admitting diagnosis): | | | | |
| A Primary: | | | | |
| B Secondary: | | | | |

| | | |
|---|---|---|
| DSM IV Code: | DSM IV Code: | DSM IV Code: |

| |
|---|
| Please supply full description and details of tests/treatment supplied covered by this claim: |
| |
| |
| |

| | | | | |
|---|---|---|---|---|
| Was ECT treatment performed during this admission? | Yes | ◯ | No | ◯ |

| | | | | |
|---|---|---|---|---|
| Was the patient transferred from the hospital during this visit for any other investigations? | Yes | ◯ | No | ◯ |
| If yes, please supply the name of the hospital and nature of test/treatment performed: | | | | |

| | | | | |
|---|---|---|---|---|
| Is any further treatment required? | Yes | ◯ | No | ◯ |
| If yes, please provide details: | | | | |

## Discharge Status

| | | | | | |
|---|---|---|---|---|---|
| Home | ◯ | Still in Hospital | ◯ | Deceased | ◯ |
| Transfer to another hospital | ◯ | Please specify the name of the hospital | | | |
| Long Term Care / Nursing Home | ◯ | Please specify the name of the nursing / convalescence home | | | |

## Declaration

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| | |
|---|---|
| Print name in block capitals: | |
| Irish Life Health Doctor Code: | |
| Signature: | |
| Date: (dd/mm/yy) | |

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**Part 3 - Hospital Details:** This part to be completed in full by the Hospital.

| | |
|---|---|
| Name of hospital/place of treatment: | |
| Date of admission: (dd/mm/yy) | |
| Date of discharge: (dd/mm/yy) | |
| Time of admission: (hh.mm) | |
| Time of discharge: (hh.mm) | |

| Room Type | Please tick | Ward/Room Name/Number | Bed number | Number of days in each bed |
|---|---|---|---|---|
| Private room | ◯ | | | |
| Semi-private room | ◯ | | | |

| | |
|---|---|
| Total number of days the patient did not occupy the above bed(s) during this admission: | |

| | |
|---|---|
| Hospital code: | |
| Hospital stamp: | |

Please attach bill with relevant procedure code.

Print Clear