PUBLIC HOSPITAL CLAIM FORM

For office use only

MAKING A CLAIM

In order to create a valid claim, please ensure all questions listed are fully answered, signatures inserted as required and all invoices (original copies only) are attached to avoid the claim being returned for completion

Page 1 should be completed by the Member or Guardian

Page 2 should be completed by the Hospital

Page 3 & 4 should be completed by the Attending Consultant/s

SECTION 1 Membership Details (Member/Guardian must complete and sign)

1.1 Staff Number: _____

(To be used as MPF Policy No)

1.2 Patient Name: _____

1.3 Address: _____

_____

_____

1.4 Date of Birth: _____ 1.5 Telephone No: _____

SECTION 2 Injury Section (For completion if applicable)

Did this hospital admission arise as a result of the following:

2.1 Road Traffic Accident Yes ☐ No ☐ 2.3 Third Party Injury Yes ☐ No ☐

2.2 Occupational Injury Yes ☐ No ☐ 2.4 Sporting Injury Yes ☐ No ☐

Are you pursuing a claim for cost against another party? _____

This question must be answered before the claim can be assessed. If the answer is yes or unsure, an indemnity form must be completed and signed before the claim will be cleared for payment. This form is available from the MPF office.

SECTION 3 Request for Private Care (to be completed by Patient/Guardian)

3.1 Did you elect to be treated as a private patient? _____

3.2 Please advise date that you opted to be treated as a private patient Date: _____

3.3 If dated after admission/discharge date, please provide the reason: _____

In electing for private care, I authorise the consultant/hospital concerned to supply all necessary information to MPF including, if requested, copies of my hospital/medical records & inclusive of medical reports. I also authorise MPF to pay the appropriate benefits for services provided to the hospital and consultants concerned. Charges which are not eligible for benefit will remain my responsibility to settle directly with the hospital or consultant.

I have signed the PRIVATE INSURANCE PATIENT FORM provided to me by the hospital and understood its contents

ESB Medical Provident Fund requires the above information to enable us to apply the benefits as per level of cover.
The data controller is ESB Medical Provident Fund.
Please refer to our Privacy Notice, available at www.esbmpf.ie or we will provide a copy on request.

I declare that the information completed above is true in every respect. _____

Name: (Block Capitals Please) _____ Date: _____

Member signature: _____

OFFICE USE ONLY P _____ V _____ A _____

SECTION 4 Hospital Details – to be completed and certified by Hospital

4.1 Hospital Name _____

4.2 Did this patient at admission elect and sign to be treated as a private patient? Yes ☐ No ☐

4.3 Was the patient admitted through Accident & Emergency? Yes ☐ No ☐

4.4 Date of Admission: _____ Time: _____

4.5 Date of Discharge: _____ Time: _____

4.6

ROOM TYPE	WARD NAME	ROOM NAME/BED NUMBER	DATES – FROM/TO	NO OF DAYS
Single Occupancy/ Private Room				
Multi Occupancy/ Semi Private Room				
Day Ward				
Sideroom				
ICU/CU/NICU				
Emergency Dept, Corridor or Other NOT COVERED BY INSURERS				

NOTE:

NB. NO PAYMENT WILL BE MADE WHERE A PATIENT IS ACCOMMODATED IN THE EMERGENCY DEPARTMENT OR IN A CORRIDOR - PATIENTS MUST BE ACCOMMODATED IN A HOSPITAL WARD BEFORE PAYMENT WILL BE APPROVED

A fully completed, signed and dated PRIVATE INSURANCE PATIENT FORM must be attached to claim before it will be assessed for payment - THIS REQUIREMENT APPLIES TO INPATIENT, DAYCASE AND SIDEROOM CLAIMS

SECTION 5 Patient Details

5.1 Name of Patient: _____ 5.2 Staff No: _____

5.3 Date of Birth: _____

SECTION 6 Diagnosis – Medical Investigators & Treatment Section TO BE COMPLETED BY THE ATTENDING CONSULTANT

6.1 Are you the admitting consultant? Yes ☐ No ☐

6.2 If no please state the name of the admitting consultant: _____

6.3 Date of onset of symptoms: _____ Date you first saw patient with symptoms: _____

6.4 Provide full details/duration of the Medical Condition necessitating the admission.

If prolonged, please provide an additional, detailed report.

6.5 Please list Primary/Secondary and other Diagnoses, indicating acute, sub acute or chronic

Primary Diagnosis: _____

Secondary / Other Diagnosis: _____

6.6 Procedure performed – please complete this section detailing surgical, diagnostic and major medical illness procedures:

PROCEDURE CODE	DATE OF SERVICE	DESCRIPTION

6.7 Details of Scans and/or tests ordered:

CONT/D.....

6.8 Did you request any other consultant services? Yes ☐ No ☐

6.9 If so, please specify consultant(s) name: Date attendance was requested:

6.10 Did you administer a General Anaesthetic to the patient? Yes ☐ No ☐

6.11 If patient was transferred from another facility, please provide details:

6.12 If patient was transferred to another facility, please provide details:

SECTION 7 Discharge Status

7.1 Date that patient completed their acute medical treatment and was fit for discharge:

7.2 Discharged to:

Home ☐	Still in hospital ☐	Transferred to other hospital ☐
Convalescent Care ☐	Long term care ☐	Deceased ☐

SECTION 8 Consultant Declaration

I hereby certify that the treatment specified was necessitated by the illness described by me above, and that the full stay in hospital was justified by the patient's medical condition. I confirm that I am a consultant with an employment contract that entitles me to claim fees for the treatment of private patients.

8.1 Name of Consultant (Block Capitals Please):

Consultant Signature (Please Sign here):

MPF Service Provider Code:

Date:

8.2 Patient's signature on this form only if treatment was provided by a Consultant in the Consultant's Private rooms and no hospital admission was necessary to perform the procedure

Patient's Signature: Date:

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