St. Pauls Garda Medical Aid Society

Plaza 255, Blanchardstown Corporate Park 2,
Ballycoolin Rd., Dublin 15.
Tel: 01 899 1604. Fax: 01 899 1707.
E-mail: customerservice@medicalaid.ie
Website: www.medicalaid.ie

Hospital Claim Form

(OFFICE USE ONLY)

If you have a query, please contact the office above for assistance.

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 to be completed in full by the Member or Guardian
Page 2 to be completed in full by the Hospital
Pages 3 and 4 to be completed in full by the Attending Consultant/s

SECTION 1 MEMBERSHIP DETAILS (Member/Guardian must complete and sign this form)

1.1 Membership Number: _____ (Staff Number as Policy No)

1.2 Patient Name: _____

1.3 Address _____

_____

1.4 Date of Birth: _____ 1.5 Telephone No: _____

SECTION 2 INJURY SECTION (Must be completed in all instances)

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

2.1 Road Traffic Accident	Yes ☐	No ☐
2.2 Injury on Duty/Occupational Injury	Yes ☐	No ☐
2.3 Third Party Injury	Yes ☐	No ☐
2.4 Sporting Injury	Yes ☐	No ☐
Are you pursuing a claim for costs against another party?	Yes ☐	No ☐

The above questions must be answered before the claim can be assessed.
If the answer is yes or you are unsure, a legal undertaking/indemnity form must be completed and signed before the claims will be cleared for payment. These forms are available from the office above.

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 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 my insurer including, if requested, copies of my hospital/medical records. I also authorise my insurer 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
(Applies to Public Hospitals only)

(OFFICE USE ONLY)

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

Member Signature _____ Date _____

SECTION 4 **Hospital Details - to be completed in full by the Hospital for all Inpatient, Daycase and Sideroom Claims. Consultant Form must be attached when claim is submitted**

4.1 Hospital name: _____

4.2 Did this patient at admission elect and sign to be treated as a private patient? Yes ☐ No ☐
(Applies to Public Hospitals only)

4.3 Was the patient admitted through A & E: Yes ☐ No ☐

4.4 Date of Admission: _____ Time: _____ Time must be provided

4.5 Date of Discharge: _____ Time _____ Time must be provided

4.6

Room Type	*Ward Name*	*Room Name / Bed No.*	*Dates - From / To*	*No. of Days*
Single Occupancy / Private Room				
Multi Occupancy / Semi- Private Room				
Day Ward				
Sideroom				
ICU / CU / NICU				
Emergency Dept, Corridoor or Other NOT COVERED BY INSURERS				

NOTE: **GARDA MEDICAL AID SOCIETY PAY MULTI - OCCUPANCY RATE ONLY WHERE A PRIVATE ROOM IS REQUESTED - PATIENT IS RESPONSIBLE FOR ANY ADDITIONAL CHARGES.**

NOTE: **NB. NO PAYMENT WILL BE MADE WHERE A PATIENT IS ACCOMMODATED IN THE EMERGENCY DEPARTMENT OR IN A CORRIDOR - PATIENT 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 BOTH INPATIENT, DAYCASE & SIDEROOM CLAIMS
(Applies to Public Hospitals only)

Cont/d .....

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

6.9 If so, please specify Consultant(s) in full: Date attendance was requested

_____ _____

_____ _____

_____ _____

_____ _____

6.10 Did you administer a General Anesthetic 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 I confirm this patient commenced Consultant led acute medical treatment on (Date) _____ and completed this treatment and was fit for discharge on (Date) _____

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 LETTERS PLEASE)

Consultant Signature: _____

Insurer Reference No: _____

Date: _____

8.2 Patients signature required on this form only if treatment was provided by a Consultant in the Consultants Private rooms and no hospital admission was necessary to perform the procedure.

Patients Signature: _____ Date: _____

SECTION 5 **PATIENT DETAILS**

Consultant Claim Form

5.1 Name of Patient: _____

5.2 Membership No: _____

5.3 Date of Birth: _____

(OFFICE USE ONLY)

5.4 Does this claim arise from an incident where a Third Party maybe liable?

Yes ☐ No ☐

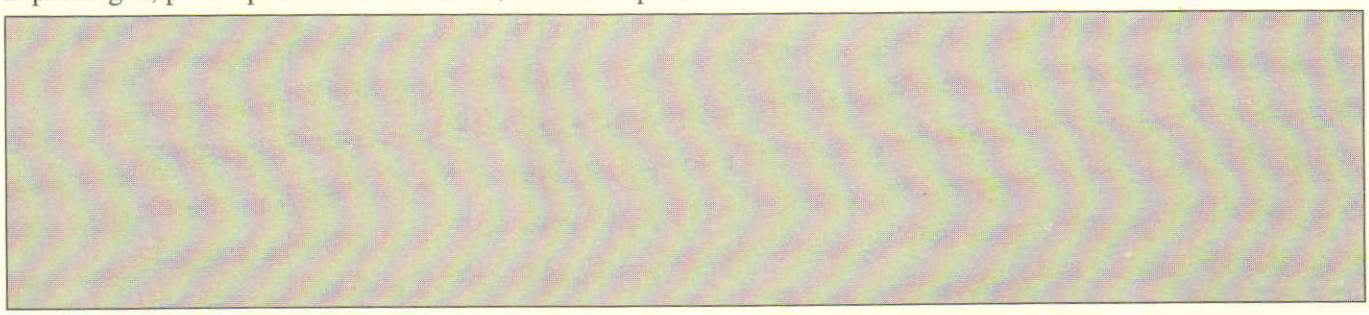
SECTION 6 **Diagnosis - Medical Investigations & Treatment Section** *To be completed by the Attending Consultant*

6.1 Are you the admitting consultant? Yes ☐ No ☐

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

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

6.4 Provide full details/duration of Medical Condition necessitating 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: _____

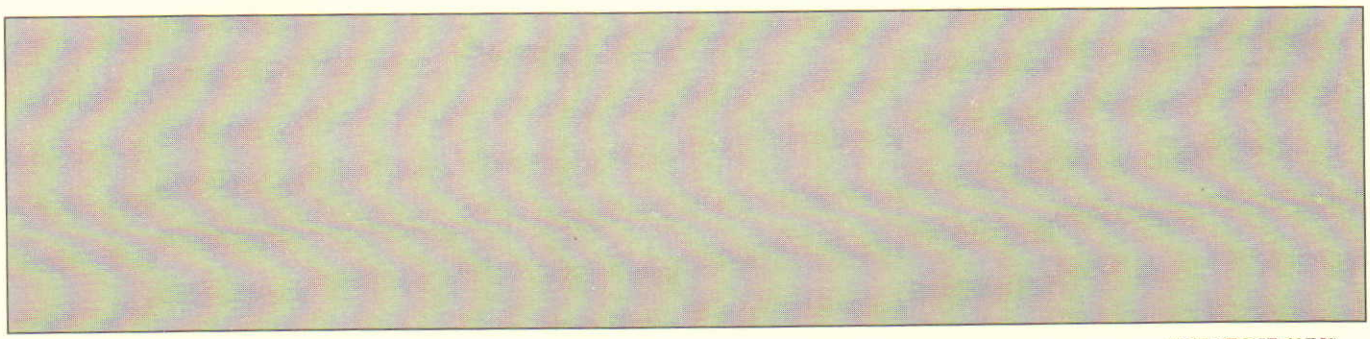
Secondary/Other Diagnosis: _____

_____

6.6 Procedure performed- please complete this section detailing surgical, diagnostic and major medical illness procedures. **Procedure code to be provided in every instance if possible**

Procedure Code	*Date of Service*	*Description*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6.7 Details of Scans and/or tests ordered



(OFFICE USE ONLY)

please turn over