In-patient, Day-case & Surgical Out-patient Treatment Claim Form

laya healthcare

In order to make a claim

Please answer all the questions below, complete the relevant sections, read and sign the declaration and consent section and ensure the original invoices are attached.

Further information

Claims should be sent by the hospital to **laya healthcare**, Eastgate Road, Eastgate Business Park, Little Island, Co. Cork.

Affix Hospital Label Here

Sections 1 - 6 to be completed in full by the policyholder/member

Policy Details

1 Policy Details

Membership no: | | | | | | | | | | | MRN no: | | | | | | | | | | |

Title: Surname: Forenames:

Date of birth: (DD/MM/YYYY) | | / | | / | | | | |

Address: Telephone: | | | | | | | | | | |

Was treatment received directly as a result of an accident? (Please place 'X' in the required box) Yes ☐ No ☐ If 'Yes' please complete section 5

Did you elect to be a **private patient** of the Consultant? (Please place 'X' in the required box) Yes ☐ No ☐

Hospital

2 Hospital Details

Hospital Name: Date of Admission: (DD/MM/YYYY) | | / | | / | | | | |

History of Illness

3 History of Illness Section

When did you/the patient first notice symptoms? (DD/MM/YYYY) | | / | | / | | | | |

When did you/the patient first consult with a doctor for this condition? (DD/MM/YYYY) | | / | | / | | | | |

Have you/the patient claimed for this or related conditions before? (Please place 'X' in the required box) Yes ☐ No ☐

If yes, when? (DD/MM/YYYY) | | / | | / | | | | |

Referral

4 Referral Details

Name of doctor first attended: Date: (DD/MM/YYYY) | | / | | / | | | | |

Doctor's Address:

PLEASE TURN OVER ➔

Sections 1 - 6 to be completed in full by the policyholder/member

Accident/Injury Details

5 Accident/Injury Section

Date of accident/injury: (DD/MM/YYYY) | | | / | | | / | | | | |

Place where accident/injury occurred?

How accident/injury occurred?

Was this accident/injury due to the fault of another party? (Please place 'X' in the required box) Yes ☐ No ☐

If yes please provide the name & address of the person, company or public body responsible.

Please provide the name of their insurance company?

Are you claiming these expenses through a Solicitor: (Please place 'X' in the required box) Yes ☐ No ☐

Or through a Personal Injuries Assesment Board: (Please place 'X' in the required box) Yes ☐ No ☐

Name & address of solicitor (where applicable):

Member Authorisation/Declaration & Consent

6 Declaration and Consent

Data Protection Statement

The information you provide will be used to manage the administration of your policy and is held in accordance with the **Data Protection Acts** 1988 and 2003 (as amended). We may need to collect sensitive information (such as medical information) about you and others named on the insurance policy. By providing this information you will be agreeing to us or our agents or other insurers processing that information for the purpose outlined above. In the event that your treatment has involved another person, or if their details are likely to be documented in your Medical Notes/File, then their express consent should be acquired in advance of sharing sensitive data. Medical information will be kept confidential and may be disclosed, on a strictly confidential basis to those involved with your treatment or care or their health professional agents. Information may also be shared with other insurers, either directly or through people acting for the insurer such as Investigators and where we are entitled to do so under the **Data Protection Acts**. However, anonymised data – that is, information which does not identify an individual – may be used by **laya healthcare**, or disclosed to others, for research or statistical purposes. Access to non-medical information may be granted by **laya healthcare** to others on a strictly confidential basis in the course of and for the purpose of the efficient administration of **laya healthcare** (for example in connection with audit, systems development, managing and improving our services). You have a right to apply for a copy of the information held by us about you (for which a small charge, not exceeding €6.35, may apply) and you have a right to have any inaccuracies in your information corrected. Please send your request in writing to the Information Protection Manager, at **laya healthcare**, Eastgate Road, Eastgate Business Park, Little Island, Co Cork.

Declaration and Consent

I declare that at the time the expenses were incurred I/the patient was entitled to private medical insurance benefits under my/the patient's chosen laya healthcare scheme. I declare that my/the patient's doctor recommended the specialist treatment and to the best of my knowledge and belief the information given on this form is true and complete. I authorise and request the hospital/specialist/consultant/physician/health provider concerned to furnish laya healthcare or its duly authorised agents acting on its behalf (including, but not limited to, medical professionals whose services are retained by laya healthcare for the purpose of assessing claims) with all necessary information as laya healthcare or its authorised agents may seek in connection with any treatment or other services provided to me or my dependant(s) for the purpose of laya healthcare considering this claim.

This includes copies of hospital/medical records related to a claim made by me, by which I mean the following in particular:

- records of physical or mental illness or ill-health;
- medical histories;
- records of treatments obtained by me;
- length of any stay in a hospital;
- discharge summaries;
- previous insurance details;
- other treatments or services received by me or my dependant(s); and

I confirm that I have read and understood the Data Protection Notice above. I confirm that I give explicit consent within the meaning of the Data Protection Acts 1988 & 2003 (as amended) to my/the patient's sensitive personal information (including my/the patient's hospital/medical records) being collected by Laya Healthcare or its authorised agents. Laya Healthcare may use this information that I have provided:

- For managing and administering my insurance policy
- For underwriting and claims handling
- To analyse, examine or clinically audit the care, claims processes and treatment/overnight-stay/convalescence/care pathway options applied/utilised by medical service providers
- To audit medical service providers generally
- To examine the handling of claims by a medical service provider.

Medical service provider means any hospital or doctor (or other healthcare professional service which is relevant).

I confirm that I give explicit consent to this sensitive personal data being held, used and processed for the above purposes and for undertaking investigations into, and to adjudicate on, my/the patient's claim (including investigations into the length of my/the patient's hospital stay and the treatment I/the patient received whilst in hospital).

I have examined and accept the accounts submitted in respect of this claim. Charges not eligible for benefit remain my responsibility to settle directly with the hospital and doctors concerned. I direct and authorise that all medical expenses (paid out by laya healthcare) recovered from the third party responsible for my/the patient's injuries shall be refunded by my solicitor directly to laya healthcare. I further direct my solicitor to deduct these amounts from my settlement cheque and reimburse laya healthcare directly. In the event that medical expenses recovered from the third party are refunded directly to me the member I agree to refund these monies directly to laya healthcare.

Patient signature (a parent or guardian if patient is under 16)

Date: (DD/MM/YYYY) | | | / | | | / | | | | |