Hospital Claim Form – Direct payment of medical charges

To make sure that you are not out of pocket, Aviva and most hospitals have a direct payment agreement that allows your claim to be settled directly between the hospital and Aviva. To facilitate this, Aviva 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 1890 717 717 at the end of your policy year. **Failure to complete the claim form correctly may result in the return of the claim in its entirety.**

Part 1

This part to be completed by the Patient and/or the Policyholder.

Patient's name: Patient's membership number:* ☐☐☐☐☐☐☐☐☐☐

Daytime contact number or mobile of patient: Patient's date of birth (day/mth/yr): ☐☐/☐☐/☐☐

Was treatment received directly as a result of an accident? Yes ☐ No ☐ Did you elect to be a private patient of the consultant? Yes ☐ No ☐

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

History of illness section

Please complete this section in full.

When did you first suffer from these symptoms or illness? (day/mth/yr): ☐☐/☐☐/☐☐

When did you first visit your doctor with these symptoms? (day/mth/yr): ☐☐/☐☐/☐☐

Name and address of doctor first attended:

Telephone number of doctor first attended:

Have you ever made a claim for this or any other similar condition in the past with Aviva or any other health insurer? Yes ☐ No ☐

If yes, please supply details of where and when:

Personal injury claims

This section is for completion in the case of personal injury.

Date of occurrence of injury (day/mth/yr): ☐☐/☐☐/☐☐ Place of injury:

Brief description of how injury occurred:

Do you plan to pursue a claim against a third party? Yes ☐ No ☐

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 and address of person, company or public body responsible:

Name of insurance company: PIAB contact name:

Name of solicitor: Solicitor contact number:

Consent

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 Aviva 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/hospital to furnish Aviva, 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 any claim regarding treatment or services received by me or my named dependants. I authorise the direct payment by Aviva to the doctors/consultant/hospital as appropriate for the services set out on this claim form to the extent provided for under my Aviva 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 Aviva statement of payment and I will have the opportunity to contact Aviva directly with any queries. Charges not covered under the Aviva 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 Aviva discharging my hospital and medical expenses to the extent of cover limits, I undertake to Aviva 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.

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 Data Protection section on **page three** of this form.

Your signature: Date:

AVIVA