Hospital Claim Form

Direct Payment

Section 1: Hospital Details - for completion by Hospital Administration Staff (Please place '**X**' in required boxes)

1.1 Hospital Code: 1.2 Hospital Name: _____

1.3 Date of Admission: D D M M Y Y 1.4 Time of Admission: H H : M M

1.5 Date of Discharge: D D M M Y Y 1.6 Time of Discharge: H H : M M

HOSPITAL STAMP REQUIRED FOR GOVERNMENT LEVY

1.7 Reimbursement Method: FPP ☐ PP ☐ PER DIEM ☐ HRS ☐ PUBLIC ☐ GOVT. LEVY ONLY ☐

1.8 Hospital Invoice Value: € . .

1.9 Hospital Admission (Please provide details of all accommodation occupied during admission including Intensive Care Unit (ICU), Coronary Care Unit (CCU) and Neonatal Intensive Care Unit (NICU)):

Type of Ward:	Please 'X'	Ward Name/Number:	Room Name/Number:	Bed Number:	Number of Beds in Room:	Number of Days:
Private Room						
Semi-Private Room						
Public Ward						
Day Ward						
ICU/NICU						
CCU						

1.10 Treatment Setting (If the patient was not admitted to a ward in the hospital, please specify the treatment setting):

Theatre ☐ Sideroom ☐ Out-patient Dept. ☐ A&E Dept. ☐ Radiology Centre ☐ Consultant/GP Rooms ☐ Minor Injury Unit ☐

1.11 Was the patient transferred directly from another facility for this procedure? Yes ☐ No ☐

If yes, name other facility: _____

Section 2: Policy Details - for completion by Policy Holder/Member (Please place '**X**' in required boxes)

2.1 **Quote Policy No. Here:** **from your Vhi membership card.**

2.2 Policy Holder's Name: _____

2.3 Policy Holder's Address: _____

_____

2.4 Is this the Policy Holder's permanent address? Yes ☐ No ☐

2.5 Patient's Name: _____

2.6 Patient's Date of Birth: D D M M Y Y

2.7 Contact Telephone No.: _____

2.8 Email Address: _____

Section 3: History of Illness - for completion by the Policy Holder/Member (Please place 'X' in required boxes)

3.1 Name of doctor first attended: _____

3.2 Date of first consultation: D D M M Y Y

3.3 Doctor's Address: _____

3.4 When was it first made known to you that this particular investigation/treatment (which is the subject of this claim) was required? D D M M Y Y

3.5 Has this patient had this or a similar illness before? Yes ☐ No ☐ 3.6 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

3.7 Are any of these expenses fully or partially recoverable from any other source? Yes ☐ No ☐

3.8 If Yes, please give details: _____

3.9 How many **weeks** did you wait for an out-patient appointment with your consultant following your GP referral? ☐☐

3.10 When your consultant decided that admission to hospital was necessary, how many **weeks** were you waiting for your admission? ☐☐

3.11 Did you elect to be a private patient of the admitting consultant? Yes ☐ No ☐

3.12 If transferred from a public facility, did you elect to be a private patient of the admitting consultant in that facility? Yes ☐ No ☐

3.13 Is your admission/treatment related to a Clinical Research Study? Yes ☐ No ☐

Section 4: Injury Details - for completion in all cases involving injury (even if no third party is involved) (Please place '**X**' in required boxes)

4.1 Date of injury: D D M M Y Y 4.2 Place of injury: _____

4.3 Brief description of how the injury occurred: _____

_____

4.4 Do you intend to pursue a legal claim against a third party (parties)? Yes ☐ No ☐

4.5 Name and address of solicitor (where applicable): _____

_____

In consideration of Vhi discharging my hospital and medical expenses to the extent of my cover limits and in accordance with the Rules of my contract with Vhi, I agree to include these expenses as part of my current (or future) claim against a third party(ies). Where I pursue a claim against a third party, either through the Courts or other Tribunals/Boards (and where I have legal representation), I hereby irrevocably authorise the solicitor(s) representing me in making that claim to furnish to Vhi an undertaking in the following form: "In consideration of Vhi discharging the eligible hospital and medical expenses of my client, I hereby agree to include as part of my client's claim the monies so paid by Vhi (details of which will be supplied to me by Vhi) and subject to any court order to the contrary, to repay to Vhi - out of the net proceeds of the settlement that come into our hands - all monies recovered in respect of such expenses paid by Vhi." Where my claim is adjudicated upon by the Injuries Board or the Criminal Injuries Compensation Tribunal and where I do not engage legal representation, I hereby agree to include as part of my claim the monies so paid by Vhi (details of which will be supplied to me by Vhi) and subject to any order/award to the contrary, to repay to Vhi - out of the net proceeds of the settlement that come into our hands - all monies recovered in respect of such expenses paid by Vhi. I further authorise Vhi to provide the Injuries Board and/or my legal representative with details of all claims paid by Vhi relating to my third party case and for the Injuries Board/my legal representative to release to Vhi full details of the Injuries Board assessment or other agreed settlement with a third party. In circumstances of an anticipated reduced settlement I agree to contact Vhi upon it being made known to me that monies so paid by Vhi may not be fully recoverable. When a reduced settlement has been agreed, I will provide Vhi with a Certificate from my legal representatives in the format agreed between the Law Society and Vhi confirming that the net proceeds recovered is the amount actually recovered. In addition, I agree to provide a Certificate from Counsel (if Counsel was instructed in relation to the settlement/hearing), confirming the veracity of the net proceeds recovered.

Section 5: Policy Holder/Member Authorisation

Data Protection and Consent

The personal data and sensitive personal data that you provide to the Vhi Group ("Vhi") in this Claim Form, or which you authorise third parties to provide, will be used within the Vhi group of companies for claims processing, claims auditing (including clinical and billing audits), policy administration and customer care purposes. Data may also be used for statistical analyses and the detection and prevention of fraud. We may share your data with trusted third parties who process data or conduct clinical and/or billing audits on our behalf, inside and outside of the European Economic Area. We may also share your data with other insurers to verify your cover, and with state bodies as required by law. Clinical audit is a clinically led quality improvement process that seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and to act to improve care where standards are not met.

I confirm that I give explicit consent to my data, including up-to-date medical diagnoses information, being held, used and processed for the purposes described above, including the purpose of undertaking investigations into, and to adjudicate on, my claim (including the length of my hospital stay and the treatment I received) and for the purposes of Vhi providing me with information about products and services aimed at managing my health and wellbeing.

You have the right, subject to certain exemptions, to access any of your personal data that we hold (for which we may charge you a small fee) and to have inaccuracies corrected. If you wish to avail of these rights, please write to the Data Protection Officer, Vhi House, 20 Lower Abbey Street, Dublin 1.

Vhi's Data Protection Statement contains a further detailed breakdown of the personal data we collect in relation to our customers and how we use that personal data. The Data Protection Statement can be found at **www.vhi.ie** or should you wish to contact us on **1890 44 44 44**, you can request a hard copy.

Declaration: I declare that the information completed above at the time of signing this declaration is true in every respect. I authorise the medical practitioner/treatment facility concerned to supply all necessary information to Vhi or its duly authorised agents acting on its behalf including, if requested, copies of my hospital/medical records in relation to this claim regarding treatment or services received by me.

I also authorise Vhi to pay the appropriate benefits for services provided to the treatment facility and medical practitioners concerned. I understand that details of these amounts will be included in my Vhi statement of payment, and I will contact Vhi directly with any queries. Charges which are not eligible for benefit will remain my responsibility to settle directly with the medical practitioner/treatment facility concerned.

X Policy Holder's/Member's Signature (You must sign here) _____ Date: D D M M Y Y

Please check that you have entered your Policy Number.

Claims statements are normally sent to the subscriber of the policy. If you are the claimant in this instance, but you are not the subscriber and you wish to have the claims statement sent to you directly, please phone us on **1890 44 44 44** or visit us at **www.vhi.ie/contact/.** Please note the address you provide in Section 2 is used purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Service Helpline at **1890 44 44 44.**

Section 6: Medical History - for completion by the Admitting Consultant (Please place 'X' in required boxes)

6.1 Patient's Name: _____ 6.2 Are you the admitting consultant? Yes ☐ No ☐

If No, please state the name of the admitting consultant: _____

6.3 By whom was the patient referred to you? _____

6.4 Nature of symptoms/signs: _____

6.5 Duration of symptoms/signs: HOURS (H H) DAYS (D D) WEEKS (W W) MONTHS (M M) YEARS (Y Y) 6.6 Date patient first consulted you with symptoms/signs: (D D M M Y Y)

6.7 Was admission: Planned ☐ Emergency ☐ 6.8 Has the patient had a previous admission for this condition? Yes ☐ No ☐

6.9 Has the patient a history of this condition? Yes ☐ No ☐ 6.10 If Yes, please give date and details: Date: (D D M M Y Y)

Details: _____

6.11 Is the admission/treatment related to a Clinical Research Study? Yes ☐ No ☐

Section 7: Medical Investigations - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

7.1 Laboratory Investigations

Biochemistry ☐ Histopathology ☐ Microbiology ☐ Immunology ☐ Haematology ☐ Endocrinology ☐ Other ☐

Summary of key diagnostic tests performed:

7.2 If any laboratory tests were performed at another facility, please state tests and facility: _____

7.3 Radiology Investigations

X-Rays ☐ Ultrasounds ☐ CT Scans ☐ MRIs ☐ PET-CTs ☐ Others ☐

Summary of key diagnostic tests performed:

7.4 If any radiology investigations were performed at another facility, please state tests and facility: _____

7.5 Please give Clinical Indication Description and Clinical Indication Code for MRI/PET-CT Scan: Clinical Indicator Code: Date:

_____ ☐☐☐☐ (D D M M Y Y)

_____ ☐☐☐☐ (D D M M Y Y)

7.6 If the MRI/PET-CT was performed at another facility, please state the facility: _____

Section 8: Diagnosis - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

8.1 Please list primary, secondary and other diagnoses, indicating whether acute, sub-acute or chronic:

Primary Diagnosis: _____

Secondary/Other Diagnoses: _____

8.2 Does this illness contain any addictive elements (alcohol, drug or other substance abuse)? Yes ☐ No ☐

8.3 If Yes, and if not full stay, please indicate dates of treatment relating to addictive illness: START DATE (D D M M Y Y) END DATE (D D M M Y Y)

Section 9: Treatment Section - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

9.1 Procedures Performed - Please complete this section detailing surgical, diagnostic and major medical illness procedures and include Clinical Indication Code and description for Surgical Procedures.

Procedure Code:	Date of Service:	Procedure Description:	Anaesthesia:	General	Regional	Monitored
	D D M M Y Y					
Procedure Code:	Date of Service:	Procedure Description:	Anaesthesia:	General	Regional	Monitored
	D D M M Y Y					
Procedure Code:	Date of Service:	Procedure Description:	Anaesthesia:	General	Regional	Monitored
	D D M M Y Y					

9.2 Clinical Indicator Code(s): Clinical Indicator Description(s):

9.3 If drug eluting stents were used, please specify the number:

9.4 If patient was transferred to another facility for a procedure, please state procedure and facility:

9.5 Please state reason for overnight/extended admission for procedures designated as One Night Only, Day Care or Side Room:

9.6 Were IV medications/IV fluids administered to the patient? Yes No

9.7 Medical Attendance - In non-surgical cases please list medical management including IV medications/IV fluids and/or treatments prescribed.

Description of treatment:

START DATE D D M M Y Y END DATE D D M M Y Y

9.8 General - Did you personally provide the services for which you have billed? Yes No

9.9 If No, please specify who provided the treatment:

Section 10: Other Services - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

10.1 Did you request radiological guidance or any other consultant(s') services? Yes No

10.2 If Yes, please specify Consultant(s') name(s) in full:

Section 11: Discharge Status - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

11.1 Home Still in this hospital Transfer to another hospital Convalescence Long-term care Deceased

11.2 Is any further treatment anticipated? Yes No If Yes, please give details:

Section 12: 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.

X Consultant's Signature (You must sign here)		Consultant Code:
		Date: D D M M Y Y

Guidelines to making a Claim

Where we operate a direct payment arrangement we will pay your hospital benefit direct to the relevant hospital/treatment centre. Under the terms of the Finance Act, 1988, we are obliged to pay benefit in respect of consultants' fees directly to the consultants concerned. We will send you a statement of the benefits paid on your behalf.

It would help us give you a speedier service and keep down administration costs if you could observe these guidelines when submitting a claim.

Section 1 to be **fully** completed by the **Hospital Administration Staff**.

Sections 2, 3, 4, and 5 are to be **fully** completed by the **Policy Holder** or **Insured Member**. Please note that **Section 4 (Injury Section)**, must be **fully** completed in all cases involving injury, even if no third party is involved.

Sections 6, 7, 8, 9, 10, 11 and 12 are to be **fully** completed by the **Admitting Consultant**.

Claim Form
Submission Address: Vhi, PO Box 10143, Dublin 18.

Dublin:	Vhi House, Lower Abbey Street, Dublin 1. Fax: (01) 873 4004
Cork:	Vhi House, 70 South Mall, Cork. Fax: (021) 427 7901
Kilkenny:	IDA Business Park, Purcellsinch, Dublin Road, Kilkenny. Fax: (056) 776 1741
Office opening hours:	10am-4pm Monday to Friday.
Tel:	1890 44 44 44. Lines open 8am-6pm Monday to Friday and 9am-3pm Saturday.
Contact:	Vhi.ie Vhi.ie/contact

QUALITY
ISO 9001:2008
NSAI Certified

JULY 2015
HDCF11