

# 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:

1.4 Time of Admission:   :

1.5 Date of Discharge:

1.6 Time of Discharge:   :

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))

HOSPITAL STAMP  
REQUIRED FOR  
GOVERNMENT LEVY

Type of Ward:	Please 'X'	Ward Name/Number:	Room Name/Number:	Bed Number:	Number of Beds in Room:	Number of Days:
Private Room	<input type="checkbox"/>					
Semi-Private Room	<input type="checkbox"/>					
Public Ward	<input type="checkbox"/>					
Day Ward	<input type="checkbox"/>					
ICU/NICU	<input type="checkbox"/>					
CCU	<input type="checkbox"/>					

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 Department  A & E Department  Radiology Centre  Consultant/GP Rooms  Minor Injury Unit

## 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 Healthcare 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:

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:

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?

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

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 If in a public ward, did you elect to be a private patient of the admitting consultant? Yes  No

3.12 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:       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 Healthcare discharging my hospital and medical expenses to the extent of my cover limits and in accordance with the Rules of my contract with Vhi Healthcare, I undertake to Vhi Healthcare 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 Healthcare an undertaking in the following form: "In consideration of Vhi Healthcare discharging the eligible hospital and medical expenses of my/our client, I/we hereby undertake to include as part of my/our client's claim the monies so paid by Vhi Healthcare (details of which will be supplied to us by Vhi Healthcare) and subject to any court order to the contrary, to repay to Vhi Healthcare - out of the proceeds that come into our hands - all such monies paid by Vhi Healthcare". Where my claim is adjudicated upon by the Personal Injuries Assessment Board (PIAB) or the Criminal Injuries Compensation Tribunal and where I do not engage legal representation, I hereby undertake to include as part of my claim the monies so paid by Vhi Healthcare (details of which will be supplied to me by Vhi Healthcare) and subject to any order/award to the contrary, to repay to Vhi Healthcare - out of the proceeds that come into my hands - all such monies paid by Vhi Healthcare. I further authorise Vhi Healthcare to provide PIAB with details of all monies paid by Vhi Healthcare relating to my application and for PIAB to release to Vhi Healthcare details of their assessment in relation to the monies paid by Vhi Healthcare.

**X** Signature \_\_\_\_\_  
Injured Member (if over 18)

**X** Policy Holder's Signature \_\_\_\_\_  
(if under 18)

### Section 5: Policy Holder/Member Authorisation

I declare that the foregoing statements are true in every respect. I authorise the consultant/hospital concerned to supply all necessary information to Vhi Healthcare including, if requested, copies of my hospital/medical records. I also authorise Vhi Healthcare to pay the appropriate benefits for services provided to the hospital and consultants concerned. I understand that details of these amounts will be included in my Vhi Healthcare statement of payment, and I will contact Vhi Healthcare directly with any queries. Charges which are not eligible for benefit will remain my responsibility to settle directly with the hospital or consultants concerned.

**X** Policy Holder's/Member's Signature (You must sign here) \_\_\_\_\_ Date:

Please check that you have entered your Policy Number

DATA PROTECTION NOTICE - The information you provide becomes part of the personal data held by Vhi Healthcare and is automated. It is used for the payment of claims and for the provision and administration of health insurance products and related services. Full details of the Vhi Healthcare's use of personal data appear in the public register held by the Data Protection Commissioner.



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**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	DAYS	WEEKS	MONTHS	YEARS
HH	DD	WW	MM	YY

 6.6 Date patient first consulted you with symptoms/signs: 

DD	MM	YY
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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: 

DD	MM	YY
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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 for MRI/PET-CT Scan: \_\_\_\_\_ Date: 

DD	MM	YY
DD	MM	YY

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 diagnosis, indicating whether acute, sub acute or chronic:

Primary Diagnosis: \_\_\_\_\_

Secondary/Other Diagnosis: \_\_\_\_\_

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	END DATE
DD	DD
MM	MM
YY	YY



## 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.

Procedure Code:	Date of Service:	Procedure Description:	Anaesthesia:	
<input type="text"/>	<input type="text"/>	_____	General	Monitored
			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	_____	General	Monitored
			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	_____	General	Monitored
			<input type="checkbox"/>	<input type="checkbox"/>

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

9.3 If patient was transferred to another facility for a procedure, please state procedure and facility: \_\_\_\_\_

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

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

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

Description of treatment: \_\_\_\_\_

\_\_\_\_\_

	START DATE	END DATE
	<input type="text"/>	<input type="text"/>

9.7 **General** - Did you personally provide the services that you have billed for? Yes  No

9.8 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 other consultant(s) services? Yes  No

10.2 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:





## 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**.

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**Limerick:** Gardner House, Charlotte Quay, Limerick.  
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9am-3pm Saturday.

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