

Private Ambulance Claim Form

Direct Payment



Section 1: Ambulance Details - for completion by the Ambulance Company (Please place 'X' in required boxes)

1.1 Company Code:

1.2 Name of Ambulance Company: _____

1.3 Service Date:

1.4 Invoice Value: €

1.5 Time of departure at hospital of origin: :

1.6 Time of arrival at hospital of destination: :

1.7 Type of Vehicle: Full Front Line Ambulance Intermediary Ambulance 1.8 Ambulance Reg. No.:

1.9 Number of Patients: 1.10 Length of Journey: Local Long 1.11 Type of Journey: Single Return

Section 2: Ambulance Authorisation - for completion by the Ambulance Company

X Signature (You must sign here) _____ Date:

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

3.1 Quote Policy No. Here:

3.2 Policy Holder's Name: _____

3.3 Policy Holder's Address: _____

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

3.5 Date of Service:

3.6 Hospital of Origin: _____

3.7 Date of hospital admission:

3.8 Date of hospital discharge (if known):

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

3.10 Patient's Name: _____

3.11 Patient's Date of Birth:

3.12 Contact Telephone No.: _____

3.13 Email Address: _____

3.14 Patient's Address: _____
(if different from Policy Holder's Address)



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 _____ **X** Policy Holder's Signature _____
Injured Member (if over 18) (if under 18)

Section 5: Policy Holder/Member Authorisation

I declare that the foregoing statements are true in every respect. I authorise the consultant/ambulance company concerned to supply all necessary information to Vhi Healthcare, if requested, copies of my hospital/medical records. I also authorise Vhi Healthcare to pay the appropriate benefits for services provided to the ambulance company concerned. I understand that the 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 ambulance company 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.

Section 6: Medical Indications - to be completed by the Admitting/Attending Doctor (Please place 'X' in required boxes)

- 6.1 Patient's Name: _____
- 6.2 Hospital of Origin: _____ 6.3 Hospital of Destination: _____
- 6.4 Reason for Transfer: MRI Scan Angiography Convalescence CT Scan Radiotherapy AGE PET-CT Scan
 Other (Please give details) _____
- 6.5 I certify that the above patient cannot be transported by taxi ('X' to confirm agreement):
- 6.6 It is necessary that this patient be transported by: Full Frontline Ambulance Intermediary Ambulance
(Ambulance Car/Patient Transport Service etc.)
- for the following medical reason(s): _____

Section 7: Doctor Declaration

I certify that it is essential to transport the above patient by ambulance for the reasons outlined above.

X Doctor's Signature _____ Doctor Code:
(You must sign here) Date:

Doctor's Address: _____

Guidelines to making a Claim

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 and 2 should be fully completed and signed by the **Ambulance/Intermediary Ambulance Company**.

Section 3, 4 and 5 should be fully completed and signed by the **Policy Holder/Insured Member**.

Section 6 and 7 should be fully completed and signed by the **Admitting/Attending Doctor**.

Direct payment of Private Ambulance charges

As a service to you, Vhi Healthcare operates a direct payment arrangement with the private ambulance company. This allows us to settle your claim directly with the ambulance company so that you are not out of pocket. To facilitate this, Vhi Healthcare may provide information to the private ambulance company verifying your membership eligibility. All you need to do is complete **Sections 3, 4 and 5** of the claim form and the private ambulance company will submit the claim for you. Please do not submit bills directly to Vhi Healthcare. We will send you a statement of the benefits paid on your behalf.

Postal Address IDA Business Park, Purcellsinch, Dublin Road, Kilkenny. Fax: (056) 776 1741

Dublin: Vhi House, Lower Abbey Street, Dublin 1. Fax: (01) 799 4091

Cork: Vhi House, 70 South Mall, Cork. Fax: (021) 427 7901

Dun Laoghaire: 35/36 Lower George's Street, Dun Laoghaire. Fax: (01) 619 7456

Galway: Vhi House, 10 Eyre Square, Galway. Fax: (091) 564 307

Limerick: Gardner House, Charlotte Quay, Limerick. Fax: (061) 310 361

Office opening hours: 9am-5pm Monday to Friday

Tel: CallSave 1850 44 44 44.

Lines open 8am-8pm Monday to Friday and 9am-2pm Saturday.

Website: www.vhi.ie **E-mail:** info@vhi.ie

