Treatment Abroad

Claim Form

Section 1: Hospital Details - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

As receipts will not be returned you may wish to retain copies prior to submission.

1.1 Hospital Name: ______________________________

1.2 Hospital Address: ______________________________

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

1.7 Type of Ward: Private Room ☐ Semi-Private Room ☐ Public Ward ☐ Day Ward ☐ Out-Patient Dept. ☐

1.8 Please confirm type of facility: Public ☐ Private ☐

Section 2: Policy Details - for completion by the 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: ______________________________

____

____

____

2.6 Patient's Name: ______________________________

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

2.8 Contact Telephone No.: ______________________________

2.9 Email Address: ______________________________

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

2.5 Patient's residential address: ______________________________

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

3.1 Please indicate the patient's reason for travel: Business ☐ Holiday ☐ Other ☐

3.2 If other, please specify: ______________________________

3.3 Travel Dates – outward journey Date: D D M M Y Y   3.4 Travel Dates – inward journey Date: D D M M Y Y

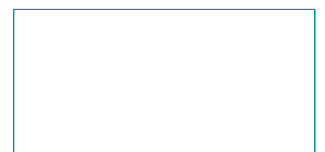
3.5 Did the patient travel abroad specifically for the treatment which is the subject of this claim? Yes ☐ No ☐

3.6 Is patient ordinarily resident outside Ireland? Yes ☐ No ☐   3.7 If Yes, please provide details: ______________________________

____

3.8 Please specify the country where the treatment, which is the subject of this claim, was received:

____



SEPTEMBER 07
TACF2

General Information

This claim form is for eligible expenses arising from acute hospital care only. Invoices eligible for inclusion under the out-patient scheme should not be included with this claim but can be included as part of an annual out-patient claim subject to the rules of the scheme.

In accordance with the terms of your insurance contract with us, you must notify Vhi Healthcare immediately of any changes to your policy or circumstances which could alter the assumption on which the contract is based or which are material to the contract.

For the purpose of qualifying for benefit in respect of emergency treatment during a temporary stay abroad, such a stay is defined under the Vhi Healthcare Rules - Terms and Conditions of Membership 'definitions' as a stay(s) outside of Ireland for any period up to but not exceeding 180 days in each calendar year.

If you or another member are entitled to claim under any other insurance policy for any of the costs, charges or fees for which you are insured under your Vhi Healthcare contract, we will pay only our rateable proportion of these costs. When making a claim you must tell us if you have other insurance.

Vhi Healthcare does not provide cover if the member travels abroad specifically to get treatment. However, in exceptional circumstances and subject to prior approval and satisfaction in full of specified criteria, we will pay up to the plan amounts outlined in the Table of Benefits.

Further details can be obtained from our offices.

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.

Where treatment is provided in a public facility in an EU member state the cost of treatment may be covered through your European Health Insurance. You are advised when travelling abroad to an EU member state to bring a European Health Insurance Card with you - contact your local Health Service Executive Area for further details.

AS RECEIPTS WILL NOT BE RETURNED, YOU MAY WISH TO RETAIN COPIES PRIOR TO SUBMISSION

Section 1, 2, 3, 4, 5 and **6** are to be **fully** completed by the **Policy Holder or Insured Member**. Please note that **Section 5 (Injury Section)**, must be **fully** completed in all cases involving injury, even if no third party is involved.

Sections 7, 8, 9, 10, 11, 12 and **13** are to be **fully** completed **by the Admitting Doctor**.

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

SEPTEMBER 07
TACF2

3.9 Did the patient obtain a European Health Insurance Card to cover the period during which treatment was received? (For more information, please see guidelines to making a claim) Yes ☐ No ☐

3.10 Did the patient make contact with Vhi Healthcare World Medical Assistance as advised on the Vhi Healthcare Membership Card? Yes ☐ No ☐

3.11 If Yes, please give contact date: D D M M Y Y

3.12 Did Vhi Healthcare World Medical Assistance agree to take on the case and cover the patient's expenses? Yes ☐ No ☐

3.13 Did the patient have Travel/Accident Insurance covering this trip abroad? Yes ☐ No ☐

3.14 If Yes please specify details:

Travel Policy Number: ☐☐☐☐☐☐☐☐☐☐

Travel Policy Excess: € ☐☐☐☐☐.☐☐

Travel Agency: ______________________

Travel Insurance Company: ______________________

3.15 Describe Cover/Plan: ______________________

A copy of the patient's Travel Insurance Policy must accompany this claim.

Section 4: History of Illness - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

4.1 Name of doctor first attended: ______________________

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

4.3 Doctor's Address: ______________________

4.4 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

4.5 Has this patient had this or a similar illness before? Yes ☐ No ☐

4.6 If Yes, please give date and details: D D M M Y Y

Details: ______________________

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

4.8 If Yes, please give details:

____

Section 5: Injury Details - for completion in all cases involving injury (even if no third party is involved) (Please place '**X**' in required boxes)

5.1 Date of injury: D D M M Y Y

5.2 Place of injury: ______________________

5.3 Brief description of how the injury occurred: ______________________

____

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

5.5 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 6: Policy Holder/Member Authorisation

I declare that the foregoing statements are true in every respect. I authorise the doctors/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 doctors concerned, where appropriate. 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 and doctors concerned.

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

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.

SEPTEMBER 07
TACF2

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

7.1 Patient's Name: ______________________ 7.2 Are you the admitting doctor? Yes ☐ No ☐

7.3 Doctor's Name and Address: ______________________

7.4 By whom was the patient referred to you? ______________________

7.5 Nature of symptoms/signs: ______________________

7.6 Duration of symptoms/signs: HOURS H H DAYS D D WEEKS W W MONTHS M M YEARS Y Y 7.7 Date patient first consulted you with symptoms/signs: D D M M Y Y

7.8 Was admission: Planned ☐ Emergency ☐ 7.9 Has the patient had a previous admission for this condition? Yes ☐ No ☐

7.10 Has the patient a history of this condition? Yes ☐ No ☐ 7.11 If Yes, please give date and details: Date: D D M M Y Y

Details: ______________________

____

Section 8: Medical Investigations - for completion by the Admitting Doctor (Please place '**X**' in required boxes)

8.1 Laboratory Investigations

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

Summary of key diagnostic tests:

8.2 Radiology Investigations

X-Rays ☐ Ultrasound ☐ CT Scan ☐ MRI ☐ PET-CT ☐ Other ☐

Summary of key diagnostic tests:

8.3 If an MRI Scan was carried out please answer the following:

Date: Please give Clinical Indication Description for MRI Scan:

D D M M Y Y ______________________

D D M M Y Y ______________________

SEPTEMBER 07
TACF2

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

9.1 Please list primary, secondary and other diagnosis, indicating whether acute, sub acute or chronic:

Primary Diagnosis: ______________________________

Secondary/Other Diagnosis: ______________________________

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

9.3 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 10: Treatment Section - for completion by the Admitting Doctor (Please place '**X**' in required boxes)

10.1 **Procedures Performed** - Please complete this section detailing procedures performed, medical management and treatments prescribed.

Date of Service:	Procedure Description:	Anaesthesia: General	Monitored
D D M M Y Y	______________________________	☐	☐
D D M M Y Y	______________________________	☐	☐
D D M M Y Y	______________________________	☐	☐

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

10.3 **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

Section 11: Other Services - for completion by the Admitting Doctor (Please place '**X**' in required boxes)

11.1 Did you request other consultant(s) services? Yes ☐ No ☐

11.2 Consultant(s) name(s) in full: ______________________________

Section 12: Discharge Status - to be completed by the Admitting Doctor (Please place '**X**' in required boxes)

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

12.2 Is any further treatment anticipated? Yes ☐ No ☐ If Yes, please give details: ______________________________

Section 13: Doctor 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 Doctor's Signature (You must sign here) ______________________________ Date: D D M M Y Y

SEPTEMBER 07
TACF2