# Hospital Claim Form

Non-Direct Payment

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

AS INVOICES/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

HOSPITAL STAMP REQUIRED FOR GOVERNMENT LEVY

1.7 Hospital Invoice Value: € _____ . __

1.8 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 | | | | | | |

1.9 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 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's 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: ____________________

SEPTEMBER 07
HNDCF2

14452 VHI Hosp Non Direct Form.qxd 20/09/2007 11:49 Page 2
USE THIS CROP MARK

## 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.

**Sections 1, 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**.

Please attach all accounts securely to the form.

***This claim form should not be used to claim benefits for treatment in hospitals and treatment centres where Vhi Healthcare has direct payment arrangements in place.***

### Direct Payment of benefit towards professional fees to consultants

Under the Finance Act, 1988, Vhi Healthcare is required to pay benefit in respect of consultants' fees **direct to the consultants concerned**. We are also required to deduct Withholding Tax from these payments and remit it to the Revenue Commissioners. **This does not, in any way, affect or reduce the value of your Vhi Healthcare cover.**

As the costs of consultant treatment vary, we advise you to obtain an estimate of all the likely professional fees before treatment begins.

| | |
|---|---|
| **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
HNDCF2

SEPTEMBER 07
HNDCF2
PERFORATION
USE THIS CROP MARK

## 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: DD MM YY

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? DD MM YY

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

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: DD MM YY 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 direct to the 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 and consultants concerned.

**X** Policy Holder's/Member's Signature (You must sign here) ______________________ Date: DD MM YY

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
HNDCF2

## 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 ☐

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 ☐ MRI's ☐ PET-CT's ☐ 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:

____________________ 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 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 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.

| Procedure Code: | Date of Service: | Procedure Description: | Anaesthesia: General | Anaesthesia: Monitored |
|---|---|---|---|---|
| ☐☐☐☐☐ | DD MM YY | ______ | ☐ | ☐ |
| ☐☐☐☐☐ | DD MM YY | ______ | ☐ | ☐ |
| ☐☐☐☐☐ | DD MM YY | ______ | ☐ | ☐ |

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

9.3 If patient was transferred for a procedure, please state procedure and facility: ______

9.4 Please state reason(s) for overnight admission for procedures designated as 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 DD MM YY END DATE DD MM YY

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: DD MM YY

SEPTEMBER 07
HNDCF2