

## Charges and Exemptions

**Article 4 (2) of the Health (In-Patient Charges) Regulations, 1987 (as amended in 1994, 1997 and 2000) provides that the charge to be made for:**

**In-Patient Services:** The charges will apply to services availed of in public, semi-private and private accommodation in Public Hospitals.

## Exemptions from Charges

Persons exempted from charges are set out in Article 4 (1) of the Regulations. Categories include:

- (i) Medical card holders and their dependants:- (Category 1)
- (ii) Women receiving services in respect of motherhood
- (iii) Children up to six weeks of age
- (iv) Children suffering from prescribed diseases and disabilities
- (v) Children referred for treatment from child health clinics and school health examinations
- (vi) Persons receiving services in respect of specific infectious diseases
- (vii) Persons in receipt of long-term care in geriatric, psychiatric or mental handicap institutions

### Postal Address: Vhi Healthcare, PO Box 10143, Dublin 18.

Kilkenny: IDA Business Park, Purcellbinch, 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 - Friday

**Tel: CallSave 1850 44 44 44. Lines open 8am-8pm Monday to Friday and 9am-2pm Saturday.**  
**Website: [www.vhi.ie](http://www.vhi.ie) E-mail: [info@vhi.ie](mailto:info@vhi.ie)**

# Plan P Hospital Claim Form

Non-Direct Payment

# Hospital



*When you need us, we're there*

**Vhi**  
HEALTH CARE



**HISTORY OF ILLNESS** (PLEASE FULLY COMPLETE THIS SECTION)

Name of Doctor first attended: \_\_\_\_\_

Address: \_\_\_\_\_

Date of first consultation: \_\_\_\_\_

Was this an Accident? Yes  No 

If yes, please give details: \_\_\_\_\_

Total amount of bill enclosed: €

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. 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 doctors concerned.

**Subscriber's/member's signature**  
**YOU MUST SIGN HERE** →

Date

(PLEASE CHECK THAT YOU HAVE ENTERED YOUR MEMBERSHIP NUMBER)

**DATA PROTECTION NOTICE** - The information you provide becomes part of the personal data held by Vhi 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's use of personal data appear in the public register held by the Data Protection Commissioner.

**FOR COMPLETION BY THE DOCTOR WHO ATTENDED THE PATIENT IN HOSPITAL**

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Final Diagnosis: \_\_\_\_\_

**Full Details of Treatment:** - If surgery was performed please give a full description of all procedures, together with relevant dates.

PROCEDURES	DATES

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

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.

**Consultant's signature**  
**YOU MUST SIGN HERE** →

Date

Vhi Doctor Code

Address