Irish Life health

Outpatient scans
Approved Treatment Centres

To make sure that you are not out of pocket, Irish Life Health and most treatment centres have a direct payment agreement that enables your claim to be settled directly between the treatment centre and Irish Life Health. To facilitate this, Irish Life Health may provide information to the treatment centre verifying your membership eligibility.

PART 1 This part to be completed by the Patient and/or the Policy Holder.

Patient's name:

Patient's membership number:*

Daytime contact number or mobile of patient:

Patient's date of birth (dd·mm·yy):

Was treatment received directly as a result of an accident? Yes No

Did you elect to be a private patient of the consultant? Yes No

*This can be found on your membership card and on your membership certificate

History of illness section

Please complete this section in full.

When did you first suffer from these symptoms or illness? (dd·mm·yy):

When did you first visit your doctor with these symptoms? (dd·mm·yy):

Name and address of doctor first attended:

Telephone number of doctor first attended:

Have you ever made a claim for this or any other similar condition in the past with Irish Life Health or any other health insurer? Yes No

If yes, please supply details of where and when:

Personal injury claims

This section is for completion in the case of personal injury.

Date of occurrence of injury (dd·mm·yy):

Brief description of how injury occurred:

Place of injury:

Do you plan to pursue a claim against a third party? Yes No

Third party claims

This section is for completion where you are making a claim against a third party (another person, company or public body, or where another person was responsible for your injury).

Name and address of person, company or public body responsible:

Name of insurance company:

PIAB contact name:

Name of solicitor:

Solicitor contact number:

Consent

I declare that at the time I underwent medical treatment I was a party to a health insurance contract and was entitled to treatment under my Irish Life Health plan. I declare that my doctor, including accident and emergency referral, recommended the treatment and referred me to the appropriate consultant for further treatment. I declare that to the best of my knowledge, the information provided in Part 1 of this form is accurate, true and complete. I authorise the doctors, consultant or hospital to furnish Irish Life Health, or any authorised agent it may appoint to act on its behalf, with any information requested, including access to my hospital/medical records, where this is necessary in relation to treatment or services received by me or my named dependants in respect of this claim. I understand that only medical information relating to my claim will be requested by Irish Life Health. I authorise the direct payment by Irish Life Health to the doctors/consultant/hospital as appropriate for the services set out on this claim form to the extent provided for under my Irish Life Health plan. I verify the details of the accounts submitted on my behalf by the doctor/hospital/consultant as an accurate reflection of the treatment I received. I understand that the details of these amounts will be included in my Irish Life Health statement of payment and I will have the opportunity to contact Irish Life Health directly with any queries. Charges not covered under the Irish Life Health plan to which I subscribe will remain my responsibility or that of the named dependant who received the treatment to settle directly with the doctors, consultant or hospital concerned. In consideration of Irish Life Health discharging my hospital and medical expenses to the extent of cover limits, I undertake to Irish Life Health to include these expenses as part of my claim against a third party and to inform my solicitor or Personal Injury Assessment Board to this effect when pursuing any claim.

Declaration

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the Irish Life Health Privacy Notice which can be found at **http://www.irishlifehealth.ie/privacy-and-legal/privacy-statement/**

Your signature:

Date:

Please turn over

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PART 2 This part to be completed in full by the attending consultant.

Patient's Full Name:

Please state the name of the person who referred patient to you:

Nature of symptoms:

A Duration of symptoms (dd·mm·yy): ☐☐·☐☐·☐☐

B Has the patient a history of these or any related symptoms? Yes ☐ No ☐

C If yes, please give the details and dates of the treatments prior to this admission:

D Is the admission/treatment related to a clinical research study? Yes ☐ No ☐

MRI Procedure Code 1: ☐☐☐☐☐ Clinical Indication Code: ☐☐☐☐☐ Date of Procedure (dd·mm·yy): ☐☐·☐☐·☐☐

MRI Procedure Code 2: ☐☐☐☐☐ Clinical Indication Code: ☐☐☐☐☐ Date of Procedure (dd·mm·yy): ☐☐·☐☐·☐☐

MRI Procedure Code 3: ☐☐☐☐☐ Clinical Indication Code: ☐☐☐☐☐ Date of Procedure (dd·mm·yy): ☐☐·☐☐·☐☐

Description of procedures (including anatomical site being examined):

CT Procedure Code 1: ☐☐☐☐☐ Clinical Indication Code: ☐☐☐☐☐ Date of Procedure (dd·mm·yy): ☐☐·☐☐·☐☐

CT Procedure Code 2: ☐☐☐☐☐ Clinical Indication Code: ☐☐☐☐☐ Date of Procedure (dd·mm·yy): ☐☐·☐☐·☐☐

CT Procedure Code 3: ☐☐☐☐☐ Clinical Indication Code: ☐☐☐☐☐ Date of Procedure (dd·mm·yy): ☐☐·☐☐·☐☐

Description of procedures (including anatomical site being examined):

Clinical interpretation of scan / diagnosis:

Anaesthesia: General: ☐ Monitored ☐

Reason for anaesthesia:

Declaration

I hereby declare that the treatment I am claiming for was medically necessary and was appropriate for the patient's medical condition as described above.

Your signature: Date: ☐☐·☐☐·☐☐

Irish Life Health Doctor Code: ☐☐☐☐☐☐☐☐

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PART 3 This part to be completed in full by the treatment centre.

Name of treatment centre:

Treatment centre stamp:

Treatment centre code:

Type of scan: MRI ☐ CT ☐ Date of scan (dd·mm·yy): ☐☐·☐☐·☐☐ Time of scan (hh·mm): ☐☐·☐☐

Please attach bill with relevant procedure code.

Read all forms carefully and make sure you fill in the mandatory fields

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F08-5-0318