Irish Life health

Private Ambulance Patient Transfer Form

Hospital Patient sticker

Affix here

Clear Form

Print

Patient name: Patient date of birth (dd·mm·yy): ·· ·· ··

Patient address:

Irish Life Health membership/policy number:

Irish Life Health Private Ambulance Company Section

Transfer from: Transfer to:

Private ambulance company name: Medicall Vehicle Registration Number:

Crew 1 Name: Phecc registration no.:

Crew 2 Name: Phecc registration no.:

Consultant Section

Medically necessary transfer to another hospital for the following test/examination – please specify:

Medically necessary transfer to convalescence home – specify reason:

Other:

Admitting Consultant name:

Admitting Consultant signature: Date (dd·mm·yy): ·· ·· ··

Hospital Section

I confirm the above transfer occurred as specified:

Name: Title:

Dept:

Signature: Date (dd·mm·yy): ·· ·· ··

Declaration

Consent

I declare that at the time I underwent a 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 to the best of my knowledge, the information provided in this form is accurate, true and complete. I authorise Medicall to furnish Irish Life Health, or any authorised agent it may appoint to act on its behalf, with any information requested. This includes access to my hospital/medical records, where 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 verify that details of the accounts submitted on my behalf by Medicall are an accurate reflection of the treatment I received. 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 Medicall.

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

Irish Life health

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

Irish Life Health, P.O. Box 764, Togher, Cork
1890 717 717 www.irishlifehealth.ie

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