Irish Life health

Post-Natal Home Help Form

Member name:

Member policy number:

Member address:

Child(ren) name(s):

Date of birth of child(ren) (dd·mm·yy): ☐☐·☐☐·☐☐

Hospital/Place of birth:

Claim		
Service provided	Date of service	Hours worked
Total claimed		

Signed by service provider:

Irish Life Health member comments:

Validated by Irish Life Health member:

For Office Use Only

Service Provider

Name:

Number:

Telephone 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 this form is accurate, true and complete. I authorise the doctors, consultant or hospital to furnish Irish Life Health dac, or any unauthorised agent it may appoint to act on its behalf, with any information requested, including access to my hospital/medical records, where it 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 dac to the doctor/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 dac 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 doctor, consultant or hospital concerned.

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: