Irish Life health

Psychiatric Hospital Claim Form
Direct Payment of Medical Charges

To make sure that you are not out of pocket, Irish Life Health and most hospitals have a direct payment agreement that enables your claim to be settled directly between the hospital and Irish Life Health. To facilitate this, Irish Life Health may provide information to the hospital verifying your membership eligibility. All you need to do is complete Part 1 of the claim form and the hospital will submit the claim for you. If you have an out patient claim, please call 1890 717 717 at the end of your policy year. **Failure to complete the claim form correctly may result in the return of the claim in its entirety.**

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

Parent'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:

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 recommended the treatment (including accident and emergency referral) 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. This includes access to my hospital/medical records, where necessary, in relation to any claim regarding treatment or services received by me or my named dependants. 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 refl ection 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 confi rm that all the details, answers and information given in this form are true, accurate and complete. I/we confi rm 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 Data Protection section on **page 3**.

Your signature:

Date:

Please turn over

PART 2 This part to be completed in full by the admitting Doctor/Consultant/GP

Patient's Full Name:

Are you the admitting consultant? Yes ☐ No ☐ If no, please state name of admitting consultant:

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

Was the admission: Emergency ☐ Planned ☐ Was this a re-admission for the same condition? Yes ☐ No ☐

Please confirm if admission was: Voluntary ☐ Involuntary ☐ N/A ☐

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:

When did the patient first consult you with these symptoms? (dd·mm·yy): ☐☐·☐☐·☐☐

Reason for admission (admitting diagnosis):

A Primary:

B Secondary:

DSM IV Code: ☐☐☐☐ DSM IV Code: ☐☐☐☐ DSM IV Code: ☐☐☐☐

Please supply full description of treatment supplied by you under this claim:

Was ECT treatment performed during this admission? Yes ☐ No ☐

Was the patient transferred from the hospital during this visit for any other investigations? Yes ☐ No ☐

If yes, please supply the name of the hospital and nature of test/treatment performed:

Is any further treatment required? Yes ☐ No ☐

If yes, please supply outline of details:

Discharge Status: Home ☐ Still in hospital ☐ Transfer to another hospital ☐

Was patient transferred on discharge to a nursing/convalescence home by you? Yes ☐ No ☐

If yes, please supply details:

Declaration

I hereby declare that the treatment I am claiming for was medically necessary and that the length of hospital stay was appropriate for the patient's medical condition as described on this form.

Your signature: Date:

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

Please turn over

PART 3 - Hospital Details This part to be completed in full by the Hospital.

Name of hospital/place of treatment:

MRN Number:

Episode / Account Number:

Date of admission (dd·mm·yy): ·· ·· Date of discharge (dd·mm·yy): ·· ··

Time of admission (hh·mm): :: Time of discharge (hh·mm): ::

Room Type	Please Mark with an 'X'	Ward/Room Name/No.	Bed No.	No. days in each bed
Private room				
Semi-private room				

Total number of days the patient did not occupy the above bed(s) during this admission:

Hospital stamp:

Hospital code:

Please attach bill

Data Protection

Irish Life Health dac is registered with the Office of the Data Protection Commissioner to act as a data controller and data processor in relation to the personal information held about you and any other member named on your policy.

The personal information that you have provided to us or that we otherwise obtain in connection with your policy will be used to administer your policy and other insurance products provided by us, other companies in the Irish Life Group or other commercial partners, in accordance with data protection and other applicable legislation and the Office of the Data Protection Commissioner-approved Code of Practice on Data Protection for the Insurance Sector. Please do not send us any genetic test results.

We will share this information with our third party administrators and any other commercial entity for the purposes above and as required to provide our services and in order to comply with legal obligations imposed on us. We may share and use this information both inside and outside of the European Economic Area, in confidence, for these purposes. We may in certain circumstances either directly or indirectly share your personal information with other insurers for the purposes of verifying information and determining waiting periods and with insurance bodies to the extent permitted by law. If you give us false information or fail to disclose information, we will record this.

To help improve the level of service we provide, we may on occasions contact you for participation in consumer satisfaction or research surveys. Your details may be used for these purposes for 12 months after your policy has ceased.

Important: In certain instances, we may need to collect personal information, including medical or other sensitive personal information, from third parties about you and any other member named on your policy. This information will remain strictly confidential and will only be sought and used in order to provide the services set out in your contract with us and for administration of this policy. By entering into a new policy with us, or renewing or amending an existing policy with us, you are also confirming that where relevant, each member of the policy has reviewed this notice and given their consent for the disclosure to us and the use of their personal information (including information collected from third parties) in the manner and for the purposes set out in this notice.

ONLY SIGN THE DECLARATION OVERLEAF IF YOU FULLY UNDERSTAND AND HAVE MET ALL OF THE ABOVE REQUIREMENTS.

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

Irish Life health

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

F04-1-816