

# LifeStage Choices Claim Form

**Life** CHOICES  
*Stage*  
FROM VHI HEALTHCARE

## Out Patient Expenses



# Guidelines to Making a Claim

**Please read these guidelines carefully before completing your annual claim form.**

To allow us to assign the correct benefits to your claim, please complete the form in full at the end of your insurance year.

## Step 1

Collect all your out-patient receipts for your insurance year (the 12 month period from date of start of cover or renewal date).

## Step 2

For all your receipts, please make sure they have the following information on them:

1. The name of the patient.
2. The cost incurred.
3. The date of the visit.

In addition to the above, physiotherapy receipts must also state the medical condition that necessitated the treatment.

## Step 3

For each service covered calculate your claim, making sure that your calculations are based on the eligible expenses for each service. Details of the eligible expenses, which you may include in your claim, are listed on Part Two of the claim form.

## Step 4

Calculate the total amount of your claim.

## Step 5

Deduct the annual excess\*\* from your claim. There is no need to submit a claim to us if the eligible expenses\* do not exceed the specified annual excess.

\* **Eligible Expenses** - is the amount allowable for a specific service for inclusion as part of your annual claim.

\*\* **Annual Excess** - is the amount deducted from the total eligible expenses.

## Step 6

Complete and sign the claim form and submit along with your receipts to:

**Vhi Healthcare, IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.**

**If you have any queries on your LifeStage Choices benefits, please contact us on *CallSave* 1850 44 44 44**



## LifeStage Choices from Vhi Healthcare

Subscriber's name and address (BLOCK LETTERS):	<b>Membership Details</b>
	Group Name (if applicable):
	Daytime Telephone Number:
	Evening Telephone Number:
Membership Number:	E-mail Address:

Name(s) of person for whom expenses are included in this claim and their relationship to subscriber

Name	Date of Birth	Relationship	Student Status

**DECLARATION:** I declare that the expenses detailed on this form were incurred by me/or dependants covered under my membership in respect of services received during the insurance year and *do not relate to hospital or nursing home in-patient treatment of more than 24 hours duration*. I declare that, to the best of my knowledge, the foregoing statements are true in every respect.

Subscriber's/Member's Signature:

Date:

**DATA PROTECTION NOTICE -**

The information you provide becomes part of the personal data held by Vhi and is automated. It is used only 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.



# Part Two Additional Out-patient Expenses Claim

**EXAMPLE 1** Consultant visits allowance is up to €50 per visit

**SECTION A** Consultant receipts for this claim = €120.00, €60.00 and €70.00

Consultant benefit = €50.00 per visit  
Benefit for this claim (subject to applicable excess)  
= €50.00 + €50.00 + €50.00 = €150.00

**EXAMPLE 2** Pathology – Consultants fees allowance up to €20 per visit

**SECTION A** Pathology Consultants receipts for this claim (separate referrals) €30.00, €20.00 + €15.00

Pathology Consultants benefits (subject to applicable excess)  
= €20.00 + €20.00 + €15.00 = €55.00

**SECTION A:** To claim, multiply the specified allowance by the associated number of services (refer to EXAMPLE 1 & 2). Benefits apply to First Plan, First Plan Plus, Family Plan and Family Plan Plus, Forward Plan, Company Plan and Company Plan Plus

SERVICE CATEGORY	ALLOWANCE		TOTAL NO. OF VISITS/SERVICES		BENEFIT
Consultant visits	Up to €50.00 per visit	x		=	
Pathology – Consultants fees	Up to €20 per referral in an approved Out-patient Centre	x		=	
Radiology – Consultants fees	The standard benefits listed in the Schedule of Benefits for Professional Fees in an approved Out-patient Centre	x		=	
Pathology, Radiology and other diagnostic tests – Hospital charges	Agreed charges in an Approved Out-patient Centre. MRI benefit is available only in a Vhi Healthcare approved MRI Centre and if the member is referred for an MRI Scan by a Consultant to rule out certain medical conditions (See rule 6M in the Rules document Terms and Conditions of Membership)	x		=	
Home Nursing	€40 per day up to a maximum of €800 per annum	x		=	
Specified medical and surgical appliances	Contact Vhi Healthcare for details on amounts allowed			=	
Emergency Dental Treatment	Up to €500.00 per accident. Please also complete Part 3 of the claim form			=	
Maternity pre and post natal care	Allowance for pre and postnatal care carried out by a GP, Consultant or Midwife in the year of birth of your infant; First Plan, First Plan Plus, Forward Plan up to €400 Company Plan, Company Plan Plus, up to €500 Family Plan, Family Plan Plus, up to €650	x		=	
			<b>Total</b>	=	
Excess for Individual Policy €125.00 Excess for family Policy €250.00 Annual Policy limit €6,500.00			<b>Less Excess</b>	-	
			<b>Net Benefit</b>	=	

## MRI SECTION TO BE COMPLETED BY CONSULTANT

Patient Name:

Date of MRI Scan:

Name of referring Consultant:

Clinical Indication for MRI:

Name of Centre where MRI scan was carried out:

Signature of Consultant:

Vhi Dr Code:

Date:

**DECLARATION:** I declare that the expenses detailed on this form were incurred by me/or dependants covered under my membership in respect of services received during the insurance year, on the recommendation of registered medical practitioners and *do not relate to hospital or nursing home in-patient treatment of more than 24 hours duration*. I declare that, to the best of my knowledge, the foregoing statements are true in every respect.

Subscriber's/Member's Signature:

Date:

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# Part Three Medical Expenses Arising from Accident or Injury

## Accident/Injury Section

Must be completed in all cases involving an accident/injury and or physiotherapy treatment (even if no third party is involved)

Patient Name:

Date & place of Accident/Injury:

Brief description of how injury occurred:

Do you intend to pursue a legal claim against a Third Party (Parties)?

Name and Address of Solicitor:

In consideration of Vhi discharging my hospital and medical expenses to the extent of my cover limits and in accordance with the Rules of my contract with Vhi, I undertake to Vhi to include these expenses as part of my current (or future) claim against a third party(ies). Where I pursue a claim against a third party, either through the Courts or other Tribunals / Boards (and where I have legal representation), I hereby irrevocably authorise the solicitor(s) representing me in making that claim to furnish to Vhi an undertaking in the following form: "In consideration of Vhi discharging the eligible hospital and medical expenses of my/our client, I /we hereby undertake to include as part of my/our client's claim the monies so paid by Vhi (details of which will be supplied to us by Vhi) and subject to any court order to the contrary, to repay to Vhi - out of the proceeds that come into our hands - all such monies paid by Vhi". Where my claim is adjudicated upon by the Personal Injuries Assessment Board or the Criminal Injuries Compensation Tribunal and where I do not engage legal representation, I hereby undertake to include as part of my claim the monies so paid by Vhi (details of which will be supplied to me by Vhi) and subject to any order/award to the contrary, to repay to Vhi - out of the proceeds that come into my hands - all such monies paid by Vhi.

Signed: Injured Member (if over 18 years)

Subscriber: (please sign here if injury is involved)

## Emergency Dental Treatment Only

To be completed by Dental Surgeon

Date and time of first visit for oral/dental treatment after the accident:

Details of injuries to teeth requiring treatment:

Details of facial or other injuries:

State whether any of the traumatised teeth had previously been restored:

Yes  No  (if yes, please give details)

Details of treatment carried out and fees levied in chronological order:

I hereby certify that the treatment specified was necessitated by the accident described above:

Signature:

Qualifications:

Date:

Address:

