Hospital@Home Claim Form

Direct Payment

Section 1: Hospital Details - for completion by Hospital Administration Staff (Please place '**X**' in required boxes)

1.1 Facility Code: 1.2 Facility Name: _____

1.3 Date of Admission: D D M M Y Y 1.4 Time of Admission: H H : M M

1.5 Date of Discharge: D D M M Y Y 1.6 Time of Discharge: H H : M M

1.7 Reimbursement Method: PP ☐ 1.8 Admission Type: Hospital@Home: ☐

1.9 Hospital Invoice Value: € . .

Section 2: Policy Details - for completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age)

2.1 **Quote Policy No. Here:** **from your Vhi membership card.**

2.2 Patient's Name: _____ 2.4 Policy Holder's Name: _____

2.3 Patient's Address: _____ 2.5 Patient's Date of Birth: D D M M Y Y

_____ 2.6 Contact Telephone No.:

_____ 2.7 Email Address: _____

Please check that you have entered your Policy Number

Please note that the address you provide is purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Services Helpline at (056) 444 4444.

Section 3: History of Illness - for completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age) (Please place 'X' in required boxes)

3.1 Name of doctor first attended: _____ 3.2 Date of first consultation: D D M M Y Y

3.3 Doctor's Address: _____

_____

3.4 When was it first made known to you that this particular investigation/treatment (which is the subject of this claim) was required? D D M M Y Y

3.5 Has this patient had this or a similar illness before? Yes ☐ No ☐

3.6 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

3.7 Are any of these expenses fully or partially recoverable from any other source? Yes ☐ No ☐

3.8 If Yes, please give details: _____

3.9 Is your admission/treatment related to a Clinical Research Study? Yes ☐ No ☐

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Section 4: Injury Details - for completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age) (Please place 'X' in required boxes)

4.1 Date of injury: D D M M Y Y 4.2 Place of injury: _____

_____

4.3 Brief description of how the injury occurred: _____

_____

_____

_____

4.4 Do you intend to pursue a legal claim against a third party (parties)? Yes ☐ No ☐

4.5 Name and address of solicitor (where applicable): _____

_____

_____

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 agree 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 client, I hereby agree to include as part of my client's claim the monies so paid by Vhi (details of which will be supplied to me by Vhi) and subject to any court order to the contrary, to repay to Vhi - out of the net proceeds of the settlement that come into our hands – all monies recovered in respect of such expenses paid by Vhi." Where my claim is adjudicated upon by the Injuries Board or the Criminal Injuries Compensation Tribunal and where I do not engage legal representation, I hereby agree 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 net proceeds of the settlement that come into our hands - all monies recovered in respect of such expenses paid by Vhi. I further authorise Vhi to provide the Injuries Board, defence insurer and/or my legal representative with details of all claims paid by Vhi relating to my third party case and for the Injuries Board/my legal representative to release to Vhi full details of the Injuries Board assessment or other agreed settlement with a third party. In circumstances of an anticipated reduced settlement I agree to contact Vhi upon it being made known to me that monies so paid by Vhi may not be fully recoverable. When a reduced settlement has been agreed, I will provide Vhi with a Certificate from my legal representatives in the format agreed between the Law Society and Vhi confirming that the net proceeds recovered is the amount actually recovered. In addition, I agree to provide a Certificate from Counsel (if Counsel was instructed in relation to the settlement/hearing), confirming the veracity of the net proceeds recovered.

Section 5: Patient or Parent/Legal Guardian (if patient is under 18 years of age) Authorisation

Data Protection Statement

In order to adjudicate on your claim, Vhi will process the personal data that you have provided on this form, together with any personal data that you have authorised third parties to provide to us. Certain processing of your personal data is required in order for us to adjudicate on your claim and for us to be able to operate the business of providing health insurance policies, whereas some processing of your personal data is optional. You can indicate your consent to the optional processing of your personal data below.

Vhi Insurance DAC of Vhi House, Lower Abbey Street, Dublin 1 is the company that controls and is responsible for processing the personal data in relation to your claim. It will process your personal data in accordance with the Vhi Data Protection Statement which has previously been provided to you. If you would like another copy of the Vhi Data Protection Statement it is available at Vhi.ie, or you can request a copy by calling us on **(056) 444 4444**.

Obtaining Copies of Your Medical Information

In order to process and to establish the eligibility and appropriateness of your claim we will contact the facility and your treating practitioners (including, where relevant your GP) on your behalf to request a copy of all necessary information including, if requested, copies of the facility/medical records relating to the treatment and/or services received by you as part of this claim.

Optional Consents

We would like to process your personal data (or if you are a parent/legal guardian acting on behalf of a dependant under 18 years, the personal data you provide on their behalf) for the purposes set out below. This is entirely optional, **and will not affect the processing of the claim**.

☐ **Advisory** I consent to Vhi processing personal data in relation to this claim, and past claims, including details of any medical conditions and treatment, in order to undertake analysis and profiling of medical and health insurance needs. I understand Vhi will use this to identify individual needs, which will help Vhi to tailor communications and advice to me in connection with the renewal of my policy either by post, phone, email or SMS (based on my chosen method of communication).

☐ **Surveys** I consent to Vhi processing personal data in relation to this claim, and past claims, including details of any medical treatments, to allow Vhi to invite me to participate in surveys. If I am eligible to participate, I consent to Vhi contacting me to ask me to participate by post, phone, email or SMS (based on my chosen method of communication).

☐ **Direct marketing** I consent to Vhi processing my personal data in relation to this claim, and past claims, including details of any medical conditions and treatments, to offer me personalised products and services which are relevant to my needs by post, phone, email or SMS (based on my chosen method of communication).

Withdrawal of Consent

Please note that where you have given consent to Vhi processing your personal data you may also withdraw that consent at any time. If you would like to withdraw your consent, or if you have any other queries, or if you wish to change your chosen method of communication, please contact us using any of the following channels:

- **Post:** Vhi Healthcare, IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.
- **E-Mail:** info@vhi.ie
- **Phone:** (056) 444 4444
- **Online:** MyVhi or the Vhi Health Assistant App

Authorisation – YOU MUST SIGN HERE

I declare that the information completed above at the time of signing this declaration is true in every respect. I authorise Vhi to pay the appropriate benefits, for services provided, to the treatment facility and medical practitioners concerned. I understand that the details of these amounts will be included in my Vhi statement of payment and I will contact Vhi directly with any queries. Charges which are not eligible for benefit will remain my responsibility to settle directly with the treatment facility/medical practitioner concerned.

X Signature of Patient or Parent/Legal Guardian
(on behalf of a dependant under 18 years at the time of admission)*

_____ Date: D D M M Y Y

*For claims in relation to a dependant under 18 years at the time of admission, please note that all correspondence and relevant payments will be made to the Policyholder. If the dependant turns 18 while the claim is in progress, Vhi will continue to correspond with the Policyholder until the claim is concluded.

Vhi Insurance DAC trading as Vhi Insurance is regulated by the Central Bank of Ireland.

Please check that you have entered your Policy Number in Section 2.

Please note that the address you provide is purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Services Helpline at **(056) 444 4444**.

Section 6: Medical History - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

6.1 Patient's Name: _____ 6.2 Are you the admitting consultant? Yes ☐ No ☐

6.3 Name of the Consultant/GP who referred the patient to you: _____

6.4 Referring Consultant's/GP's Vhi Practitioner Code: ☐☐☐☐☐☐

6.5 Name of the Referring Hospital: _____ 6.6 Referring Hospital Vhi code: ☐☐☐☐☐

6.7 Source of Referral: A&E ☐ Consultant's Rooms ☐ Hospital Ward ☐ GP ☐ Nursing Home ☐

6.8 Nature of symptoms/signs: _____

_____

6.9 Duration of symptoms/signs: HOURS H H DAYS D D WEEKS W W MONTHS M M YEARS Y Y

6.10 Date patient first consulted you with symptoms/signs: D D M M Y Y

6.11 Was admission: Planned ☐ Emergency ☐ 6.12 Has the patient had a previous admission for this condition? Yes ☐ No ☐

6.13 Has the patient a history of this condition? Yes ☐ No ☐ 6.14 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

_____

6.15 Is the admission/treatment related to a Clinical Research Study? Yes ☐ No ☐

Section 7: Medical Investigations - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

7.1 Were any investigations required during the course of the treatment by the Vhi Hospital@Home team? Yes ☐ No ☐

If yes, please specify:

Antibiotic Levels	☐	FBC	☐
Biochemistry	☐	CXR	☐
Microbiology	☐	Other	☐

Section 8: Diagnosis - for completion by the Admitting Consultant

Please list principal and secondary diagnoses relating to the admission, indicating whether acute, sub-acute or chronic:

8.1 Principal Diagnosis: ***(PDX = The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital)***

Vhi office use only

	ICD Code

8.2 Secondary Diagnoses: *(Additional conditions, if any, that required active management as part of the admission or affect the length of stay during this admission.* ***Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded****)*

Vhi office use only

	ICD Code
	ICD Code
	ICD Code
	ICD Code

Section 9: Treatment Section - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

9.1 Condition being treated:

Procedure Code: Procedure Description:

9.2 Criteria for initiation of intravenous antibiotics: _____

9.3 Antibiotic infused:

Procedure Code: Procedure Description:

9.4.1 Number of Days the patient was on IV antibiotic therapy only

9.4.2 Number of Days the patient was on IV antibiotic therapy plus oral antibiotic therapy

9.4.3 Number of Days the patient was on oral antibiotic therapy only

9.4.4 Number of Days the patient was on no antibiotic therapy

9.5 Was IV hydration required? Yes ☐ No ☐ If yes, please state number of days

9.6 In the case of infusions, the number of infusions required daily

9.7.1 The total number of nursing staff visits to the patient's home

9.7.2 The total number of medical practitioner visits to the patient's home

Section 10: Discharge Status - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

10.1 Please state the discharge status of the patient from the programme:

Home ☐ Transfer to another hospital ☐ Convalescence ☐ Long-term care ☐ Deceased ☐

10.2 Is any further treatment anticipated? Yes ☐ No ☐ If Yes, please give details: _____

Section 11: Consultant Declaration

I hereby certify that the treatment specified was necessitated by the illness described by me above, and that the full stay in hospital was justified by the patient's medical condition.

X Consultant's Signature (You must sign here)	_____	Consultant Code: ☐☐☐☐☐☐ Date: DD MM YY

Guidelines to making a Claim

Where we operate a direct payment arrangement we will pay your hospital benefit direct to the relevant hospital/treatment centre. We will send you a statement of the benefits paid on your behalf.

It would help us give you a speedier service and keep down administration costs if you could observe these guidelines when submitting a claim.

Section 1 to be **fully** completed by the **Hospital Administration Staff**.

Sections 2, 3, 4 and 5 are to be **fully** completed by the **Patient or Parent/Legal Guardian (if patient is under 18 years of age).**

Please note that **Section 4 (Injury Section)**, must be **fully** completed in all cases involving injury, even if no third party is involved.

Sections 6, 7, 8, 9, 10 and 11 are to be **fully** completed by the **Admitting Consultant**.

Claim Form Submission Address: Vhi, PO Box 10143, Dublin 18.

Dublin:	Vhi House, Lower Abbey Street, Dublin 1.	Fax: (01) 873 4004
Cork:	Vhi House, 70 South Mall, Cork.	Fax: (021) 427 7901
Kilkenny:	IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.	Fax: (056) 776 1741

QUALITY ISO 9001:2008 NSAI Certified

Office opening hours: 10am-4pm Monday to Friday.

Tel: (056) 444 4444.
Lines open 8am-7pm Monday to Friday and 9am-3pm Saturday.

Contact: Vhi.ie
Vhi.ie/contact

Vhi INSURANCE

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