Hospital in the 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 in the Home: ☐

1.9 Hospital Invoice Value: € . |

Section 2: Policy Details - for completion by Policy Holder/Member (Please place '**X**' in required boxes)

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

2.2 Policy Holder's Name: _____

2.3 Policy Holder's Address: _____

_____

_____

2.4 Is this the Policy Holder's permanent address? Yes ☐ No ☐

2.5 Patient's Name: _____

2.6 Patient's Date of Birth: D D M M Y Y

2.7 Home Contact No.: | | | | | | | | | | |

2.8 Mobile Contact No.: | | | | | | | | | | |

2.9 Email Address: _____

Section 3: History of Illness - for completion by the Policy Holder/Member (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 Policy Holder/Member (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 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: Policy Holder/Member Authorisation

Data Protection and Consent

The personal data and sensitive personal data that you provide to the Vhi Group ("Vhi") in this Claim Form, or which you authorise third parties to provide, will be used within the Vhi group of companies for claims processing, claims auditing (including clinical and billing audits), policy administration and customer care purposes. Data may also be used for statistical analyses and the detection and prevention of fraud. We may share your data with trusted third parties who process data or conduct clinical and/or billing audits on our behalf, inside and outside of the European Economic Area. We may also share your data with other insurers to verify your cover, and with state bodies as required by law. Clinical audit is a clinically led quality improvement process that seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and to act to improve care where standards are not met.

On the basis that Vhi shall only seek medical data relevant to this claim, I can confirm that I give explicit consent to my data, including up-to-date medical diagnoses information, being held, used and processed for the purposes described above, including the purpose of undertaking investigations into, and to adjudicate on, my claim (including the length of my hospital stay and the treatment I received).

You have the right, subject to certain exemptions, to access any of your personal data that we hold (for which we may charge you a small fee) and to have inaccuracies corrected. If you wish to avail of these rights, please write to the Data Protection Officer, Vhi House, 20 Lower Abbey Street, Dublin 1.

Vhi's Data Protection Statement contains a further detailed breakdown of the personal data we collect in relation to our customers and how we use that personal data. The Data Protection Statement can be found at **Vhi.ie** or should you wish to contact us on **(056) 4 444 444** *or* **1890 44 44 44**, you can request a hard copy.

Declaration: I declare that the information completed above at the time of signing this declaration is true in every respect. I authorise the medical practitioner/treatment facility concerned to supply all necessary information to Vhi or its duly authorised agents acting on its behalf including, if requested, copies of my hospital/medical records in relation to this claim regarding treatment or services received by me.

I also authorise Vhi to pay the appropriate benefits, for services provided, to the treatment facility and medical practitioners concerned. I understand that 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 medical practitioner/treatment facility concerned.

X Policy Holder's/Member's Signature (You must sign here) _____ Date: D D M M Y Y

Please check that you have entered your Policy Number.

Claims statements are normally sent to the subscriber of the policy. If you are the claimant in this instance, but you are not the subscriber and you wish to have the claims statement sent to you directly, please phone us on **(056) 4 444 444** *or* **1890 44 44 44** or visit us at **Vhi.ie/contact/.** Please note the address you provide in Section 2 is used purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Service Helpline at **(056) 4 444 444** *or* **1890 44 44 44.**

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 HomeCare 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 **Policy Holder** or **Insured Member**. 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
Office opening hours:	10am-4pm Monday to Friday.
Tel:	(056) 4 444 444 *or* 1890 44 44 44. Lines open 8am-6pm Monday to Friday and 9am-3pm Saturday.
Contact:	Vhi.ie Vhi.ie/contact

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