Neonatal Intensive Care Medicine

Claim Form (Supplementary)

This form is for completion by the consultant who provides neonatal intensive care medicine in accordance with Vhi's Neonatal Intensive Care Ground Rules contained in the Vhi Schedule of Benefits for Professional Fees. **To be completed by the Consultant Neonatologist only and submitted attached to the patient's completed hospital claim form, which has been signed by the parent/guardian.**

Section 1: Patient Details - to be completed by attending consultant

Subscriber's Name and Address (BLOCK LETTERS)

MEMBERSHIP DETAILS

Baby's Name: _____

Baby's Date of Birth: D D M M Y Y

Please quote the patient's Membership no. here:

Section 2: Hospital Details - please fully complete this section

Name of Hospital:	Date of Admission to NICU:	Time:
Number of NICU cots in unit:	Date of Discharge from NICU:	Time:
Date of Admission to Hospital:	Specify individual NICU cot number:	

Section 3: Source of Referral - please tick appropriate box

(a) Labour Ward ☐

(b) Other Hospital ☐ Name of other hospital: _____

(c) Other Transfer ☐ Please give details: _____

_____

_____

Section 4: Initiation of Mechanical Ventilation Support - please tick appropriate box

(a) Near-term typically requiring 1 – 3 days mechanical ventilation ☐

(b) Pre-term typically requiring 1 – 2 weeks mechanical ventilation support ☐

(c) Extremely pre-term of less than 1,500 grams requiring mechanical ventilation typically for up to 3 weeks ☐

Initiation of Mechanical Ventilation Support					
Date Mechanical Ventilation Commenced	Time of Commencement	Date of Cessation	Time of Cessation	Initiated By	Patient Location (Please tick) NICU ☐ Theatre ☐

Section 5: Outcome Status - please tick appropriate box

To where was the patient discharged:

(a) Ward in same hospital:	☐	Date of transfer:	D D M M Y Y
(b) Other Hospital:	☐	Date of transfer:	D D M M Y Y
(c) Home:	☐	Date of discharge:	D D M M Y Y
(d) Deceased:	☐	Date:	D D M M Y Y

Section 6: Certification

Data Protection:
The personal data and health related data provided in this claim form will be processed in accordance with our Data Protection Statement and the requirements of the Data Protection Legislation.

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

X Consultant's Signature
(You must sign here)

_____

Vhi Doctor Code: ☐☐☐☐☐☐

Date: D D M M Y Y

Address:

PLEASE CHECK THAT YOU HAVE ENTERED THE PATIENT'S MEMBERSHIP NUMBER.

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

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MAY 2018
NICM7