Oncology CT Scan

Direct Payment

Section 1: Facility Details - for completion by Facility Staff

1.1 Facility Code: | | | | | |

1.2 Facility Name: _____

1.3 Date of Scan: D D M M Y Y

1.4 Time of Scan: H H : M M

1.5 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: _____

2.3 Patient's Address: _____

_____

_____

2.4 Policy Holder's Name: _____

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 or 1890 44 44 44

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 Oncology CT Scan related to a Clinical Research Study? Yes ☐ No ☐

3.10 How many **weeks** did you wait for an out-patient appointment with your consultant following your GP referral (if applicable)? | |

3.11 Subsequent to your GP/consultant's decision to refer you for a scan, how many **weeks** have you been waiting for your scan? | |

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MAY 2018
OCTSCF8

Section 4: 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** or **1890 44 44 44**.

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 or 1890 44 44 44
- **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 scan)*

_____ Date: D D M M Y Y

*For claims in relation to a dependant under 18 years at the time of scan, 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** or **1890 44 44 44**.

MAY 2018
OCTSCF8

Section 5: Medical History - for completion by the Attending Consultant (Please place '**X**' in required boxes)

5.1 Patient's Name: _____

5.2 By whom was the patient referred to you? (Please give doctor's name and speciality):

_____

5.3 Nature of symptoms/signs: _____

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

Please complete question 5.5 or 5.6

5.5 **Asymptomatic Patient** undergoing planned surveillance following treatment for cancer: ..... ☐

5.6 **Symptomatic Patient** CT Scans are payable for patients requiring staging and re-staging of cancer.
Please indicate which of the circumstances below have been met:-

5.6.1 To establish the extent of a definitive newly-diagonsed cancer, where such information is rquired to determine appropriate initial treatment: ..... ☐

5.6.2 During or following completion of treatment for the purpose of detecting residual disease: ..... ☐

5.6.3 To establish the extent of a documented reccurrence:..... ☐

5.6.4 Symptomatic patient identified as having a definitive clinical abnormality, either on clinical examination or as a result of other investigations, that is consistent with a reccurrence of a previously diagnosed cancer: ..... ☐

5.6.5 Please provide as much information as possible below to substantiate the case for this CT Scan:

_____

_____

5.7 Is this Oncology CT Scan related to a Clinical Research Study? Yes ☐ No ☐

Section 6: Oncology CT Scan Details - for completion by the Attending Consultant

6.1 Oncology CT Scan Procedure Code: ☐☐☐☐☐ Date of Service: (D D M M Y Y)

Procedure description (Including anatomical site being examined): _____

_____

Oncology CT Scan Procedure Code: ☐☐☐☐☐ Date of Service: (D D M M Y Y)

Procedure description (Including anatomical site being examined): _____

_____

6.2 Type of cancer for which CT Scan is being provided: _____

_____

6.3 Clinical Interpretation of CT Scan/diagnosis: _____

_____

Section 7: Consultant Declaration

I hereby certify that the Oncology CT Scan was necessitated by the circumstances described by me above, and was justified by the patient's medical condition.

X Consultant's Signature
(You must sign here)

_____

Consultant Code: ☐☐☐☐☐☐

Date: (D D M M Y Y)

Guidelines to making a Claim

This claim form is for submitting an Oncology CT Scan claim, carried out at an approved Oncology CT Scan Centre fully covered for out-patient Oncology CT Scans as specified in your Vhi Rules - Terms and Conditions of Membership.

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 is to be completed by the **Facility Staff**.

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

Sections 5, 6 and 7 are to be completed by the **Consultant who performs the scan.**

Direct payment of charges to Oncology CT Scan facility

As a service to you, Vhi and the facility have a direct payment arrangement which enables your claim to be settled between the facility and Vhi so that you will not be out of pocket. To facilitate this, Vhi may provide information to the facility verifying your membership eligibility.

All you need to do is complete **Sections 2, 3 and 4** of the claim form and the facility will submit the claim for you. Please do not submit bills directly to Vhi. We will send you a statement of the benefits paid on your behalf.

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 *or* 1890 44 44 44.
Lines open 8am-7pm Monday to Friday and 9am-3pm Saturday.

Contact: Vhi.ie
Vhi.ie/contact

Vhi INSURANCE

MAY 2018
OCTSCF8