Treatment Abroad

Claim Form

Section 1: Hospital Details - for completion by Policy Holder/Member (Please place '**X**' in required boxes)

As receipts will not be returned you may wish to retain copies prior to submission.

1.1 Hospital Name: _____

1.2 Hospital Address: _____

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 Type of Ward: Private Room ☐ Semi-Private Room ☐ Public Ward ☐ Day Ward ☐ Out-Patient Dept. ☐

1.8 Please confirm type of facility: Public ☐ Private ☐

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 residential address: _____

2.6 Patient's Name: _____

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

2.8 Contact Telephone No.: _____

2.9 Email Address: _____

Section 3: Travel Details - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

3.1 Please indicate the patient's reason for travel: Business ☐ Holiday ☐ Other ☐

3.2 If other, please specify: _____

3.3 Travel Dates – outward journey Date: D D M M Y Y 3.4 Travel Dates – inward journey Date: D D M M Y Y

3.5 Did the patient travel abroad specifically for the treatment which is the subject of this claim? Yes ☐ No ☐

3.6 Is patient ordinarily resident outside Ireland? Yes ☐ No ☐

3.7 If Yes, please provide details: _____

3.8 Please specify the country where the treatment, which is the subject of this claim, was received: _____

_____

3.9 Did the patient obtain a European Health Insurance Card to cover the period during which treatment was received? (For more information, please see guidelines to making a claim) Yes ☐ No ☐

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3.10 Did the patient make contact with Vhi World Medical Assistance as advised on the Vhi Membership Card? Yes ☐ No ☐

3.11 If Yes, please give contact date: D D M M Y Y and Vhi Reference Number: ☐☐☐☐☐☐☐☐☐☐

3.12 Did Vhi World Medical Assistance agree to take on the case and cover the patient's expenses? Yes ☐ No ☐

3.13 Did the patient have Travel/Accident Insurance covering this trip abroad? Yes ☐ No ☐

3.14 If Yes, please specify details:

Travel Policy Number: ☐☐☐☐☐☐☐☐☐☐ Travel Policy Excess: € ☐☐☐☐☐.☐☐

Travel Agency: _____ Travel Insurance Company: _____

3.15 Describe Cover/Plan: _____

Section 4: History of Illness - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

4.1 Name of doctor first attended: _____ 4.2 Date of first consultation: D D M M Y Y

4.3 Doctor's Address: _____

_____

4.4 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

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

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

Details: _____

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

4.8 If Yes, please give details: _____

_____

Section 5: Injury Details - for completion in all cases involving injury (even if no third party is involved) (Please place '**X**' in required boxes)

5.1 Date of injury: D D M M Y Y 5.2 Place of injury: _____

5.3 Brief description of how the injury occurred: _____

_____

_____

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

5.5 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 6: 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.**

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

Section 7: Checklist - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

7.1 Claim form completed? Yes ☐ No ☐

If you have contacted Vhi World Medical Assistance please complete Sections 1 – 7. If you did not contact Vhi World Medical Assistance then all sections of the claim form must be fully completed. Please ensure Sections 8 – 14 are completed by your admitting consultant. **The medical information on the claim form must be completed in English.**

7.2 Original receipts and invoices attached? Yes ☐ No ☐

If you have received prior approval from Vhi for your treatment abroad, then invoices only, are required.

7.3 Travel Policy and flight itinerary attached? Yes ☐ No ☐

If you hold Travel/Accident Insurance covering this trip abroad then a copy of the Travel/Accident Insurance Policy and flight itinerary should be attached.

Failure to provide this information may delay the payment of your claim.

Section 8: Medical History - for completion by the Admitting Doctor (Please place '**X**' in required boxes)

8.1 Patient's Name: _____ 8.2 Are you the admitting doctor? Yes ☐ No ☐

8.3 Doctor's Name and Address: _____

8.4 By whom was the patient referred to you? _____

8.5 Nature of symptoms/signs: _____

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

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

8.8 Was admission: Planned ☐ Emergency ☐ 8.9 Has the patient had a previous admission for this condition? Yes ☐ No ☐

8.10 Has the patient a history of this condition? Yes ☐ No ☐ 8.11 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

Section 9: Medical Investigations - for completion by the Admitting Doctor (Please place '**X**' in required boxes)

9.1 Laboratory Investigations

Biochemistry ☐ Histopathology ☐ Microbiology ☐ Immunology ☐ Haematology ☐ Endocrinology ☐ Other ☐

Summary of key diagnostic tests performed:

9.2 Radiology Investigations

X-Rays ☐ Ultrasounds ☐ CT Scans ☐ MRIs ☐ PET-CTs ☐ Others ☐

Summary of key diagnostic tests performed:

9.3 If an MRI Scan was carried out please answer the following:

Date: Please give Clinical Indication Description for MRI Scan:

D D M M Y Y _____

D D M M Y Y _____

Section 10: Diagnosis - for completion by the Admitting Doctor (Please place '**X**' in required boxes)

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

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

	ICD Code

10.2 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****)*

	ICD Code
	ICD Code
	ICD Code
	ICD Code

10.3 Does this illness contain any addictive elements (alcohol, drug or other substance abuse)? Yes ☐ No ☐

10.4 If Yes, and if not full stay, please indicate dates of treatment relating to addictive illness:

START DATE D D M M Y Y END DATE D D M M Y Y

Section 11: Treatment Section - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

11.1 Procedures Performed - Please complete this section detailing procedures performed, medical management and treatments prescribed.

Date of Service: D D M M Y Y | Procedure Description: _____ | Anaesthesia: General ☐ Regional ☐ Monitored ☐

_____

Date of Service: D D M M Y Y | Procedure Description: _____ | Anaesthesia: General ☐ Regional ☐ Monitored ☐

_____

Date of Service: D D M M Y Y | Procedure Description: _____ | Anaesthesia: General ☐ Regional ☐ Monitored ☐

_____

11.2 Were IV medications/IV fluids administered to the patient? Yes ☐ No ☐

11.3 Medical Attendance - In non-surgical cases please list medical management including IV medications/IV fluids and/or treatments prescribed.

Description of treatment: _____

_____

_____

_____ START DATE D D M M Y Y END DATE D D M M Y Y

Section 12: Other Services - for completion by the Admitting Doctor (Please place '**X**' in required boxes)

12.1 Did you request other consultant(s') services? Yes ☐ No ☐

12.2 Consultant(s') name(s) in full: _____

Section 13: Discharge Status - for completion by the Admitting Doctor (Please place '**X**' in required boxes)

13.1 Home ☐ Still in this hospital ☐ Transfer to another hospital ☐

Convalescence ☐ Long-term care ☐ Deceased ☐

13.2 Is any further treatment anticipated? Yes ☐ No ☐

If Yes, please give details: _____

_____

_____

Section 14: Doctor 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 Doctor's Signature (You must sign here) _____ Date: D D M M Y Y

General Information

This claim form is for eligible expenses arising from acute hospital care only. Invoices eligible for inclusion under the out-patient scheme should not be included with this claim but can be included as part of an annual out-patient claim subject to the rules of the scheme.

In accordance with the terms of your insurance contract with us, you must notify Vhi immediately of any changes to your policy or circumstances which could alter the assumption on which the contract is based or which are material to the contract.

For the purpose of qualifying for benefit in respect of emergency treatment during a temporary stay abroad, such a stay is defined under the Vhi Rules - Terms and Conditions of Membership as a stay(s) outside of Ireland for any period up to but not exceeding 180 days in each calendar year.

If you or another member are entitled to claim under any other insurance policy for any of the costs, charges or fees for which you are insured under your Vhi contract, we will pay only our rateable proportion of these costs. When making a claim you must tell us if you have other insurance.

Vhi does not provide cover if the member travels abroad specifically to get treatment. However, in exceptional circumstances and subject to prior approval and satisfaction in full of specified criteria, we will pay up to the plan amounts outlined in your Table of Benefits.

Further details can be obtained from our offices.

Guidelines to making a Claim

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

Where treatment is provided in a public facility in an EU member state the cost of treatment may be covered through your European Health Insurance. You are advised when travelling abroad to an EU member state to bring a European Health Insurance Card with you - contact your local Health Service Executive Area for further details.

AS RECEIPTS WILL NOT BE RETURNED, YOU MAY WISH TO RETAIN COPIES PRIOR TO SUBMISSION

Sections 1, 2, 3, 4, 5, 6 and **7** are to be **fully** completed by the **Policy Holder or Insured Member.** Please note that **Section 6 (Injury Section)**, must be **fully** completed in all cases involving injury, even if no third party is involved.

Sections 8, 9, 10, 11, 12, 13 and **14** are to be **fully** completed **by the Admitting Doctor.**

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) 4 444 444 *or* 1890 44 44 44.

Lines open 8am-6pm Monday to Friday and 9am-3pm Saturday.

Website: Vhi.ie

Vhi.ie/contact

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