Treatment Abroad

Claim Form

Section 1: Hospital Details - for completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age). 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 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: Travel Details - 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 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 Patient or Parent/Legal Guardian (if patient is under 18 years of age) (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, 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.

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Section 6: Patient or Parent/Legal Guardian (if patient is under 18 years of age at time of admission) 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

Declaration – YOU MUST COMPLETE THE BELOW

I declare that the expenses, details of which are submitted within this form, were incurred by me and/or members covered under the policy in respect of services received during the applicable insurance period. I have examined and accept the accounts submitted in respect of this claim and I declare that these accounts have not been altered or amended in any way.

PLEASE NOTE: IF A CLAIM SUBMITTED BY, OR ON BEHALF OF, A MEMBER IS CONSIDERED BY VHI TO BE FRAUDULENT OR DISHONEST AND SUBMITTED WITH A VIEW TO OBTAINING A BENEFIT UNDER A POLICY, NO BENEFITS WILL BE PAYABLE AND THE POLICY WILL BE CANCELLED.

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** or **1890 44 44 44**.

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Section 7: Checklist - for completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age) (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 Doctor (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

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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.

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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 **Patient or Parent/Legal Guardian (if patient is under 18 years of age).** 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

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

QUALITY
ISO 9001:2008
NSAI Certified

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