Fertility Treatment

Claim Form

Claim Form required to support each service incurred.

Section 1 Policy Details

(For completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age)).

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

1.2 Patient's Name: _____

1.3 Patient's Address: _____

_____

1.4 Policy Holder's Name: _____

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

1.6 Contact Telephone No.:

1.7 Email Address (CAPS please):

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.

Section 2 Details of Treatment in Facility

(For completion by the Treatment Centre).

Please complete the following section for benefit claimed.

2.1 Facility Code:

2.2 Date(s) of Service: D D M M Y Y D D M M Y Y D D M M Y Y D D M M Y Y

2.3 Facility Name and Location: _____

_____

_____

As benefits may vary according to your plan please refer to your Vhi Rules - Terms and Conditions of Membership and your Table of Benefits to understand the benefits you are entitled to claim under your current plan.

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Section 3 Claim Details

(For completion by the Consultant (Please place 'X' in required boxes).

3.1 Benefit claimed: IUI ☐ IVF ☐ ICSI ☐ Fertility Counselling ☐ Sperm Freezing ☐ Egg Freezing ☐

Initial Consultation ☐ Fertility Test ☐ PGT ☐ FET ☐

3.2 **International Classification of Diagnosis-10**

General information about your presentation was recorded by your clinician using standard anonymous codes, called the International Classification of Diagnoses-10 (ICD-10).

3.3 Primary Diagnosis (Underlying Cause): _____

_____ _____

3.4 Secondary Diagnosis (Underlying Cause): _____

_____ _____

3.5 Clinical Indicator Code: ☐☐☐☐☐

Clinical Indicator Description for PGT: _____

_____

Section 4 Consultant Declaration

I hereby certify that the treatment specified was necessitated by the condition 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

Section 5 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.

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**.

Authorisation – YOU MUST SIGN HERE

Where direct payment arrangements are in place with treatment facilities and/or medical practitioners, I declare that the information completed above at the time of signing this declaration to be true and accurate 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. I authorise the medical practitioner/treatment facility concerned to supply all necessary information to Vhi and any duly authorised agents acting on their behalf. This includes, if requested, copies of my hospital/medical records in relation to this claim regarding treatment or services received by me. Where expenses were incurred and are payable by me in respect of services received during the applicable insurance period, details of which are submitted within this form, 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.

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 treatment, 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 1.

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.**

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Claim Form Submission Address:

Vhi
PO Box 10143
Dublin 18

Contact Information:

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. Lines open 8am-7pm Monday to Friday and 9am-3pm Saturday.
Contact:	vhi.ie vhi.ie/contact

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