

Hospital Claim Form

Non-Direct Payment



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

AS INVOICES/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:

1.4 Time of Admission: :

1.5 Date of Discharge:

1.6 Time of Discharge: :

HOSPITAL STAMP
REQUIRED FOR
GOVERNMENT LEVY

1.7 Hospital Invoice Value: €

1.8 Hospital Admission (Please provide details of all accommodation occupied during admission including Intensive Care Unit (ICU), Coronary Care Unit (CCU) and Neonatal Intensive Care Unit (NICU)):

Type of Ward:	Please 'X'	Ward Name/Number:	Room Name/Number:	Bed Number:	Number of Beds in Room:	Number of Days:
Private Room	<input type="checkbox"/>					
Semi-Private Room	<input type="checkbox"/>					
Public Ward	<input type="checkbox"/>					
Day Ward	<input type="checkbox"/>					
ICU/NICU	<input type="checkbox"/>					
CCU	<input type="checkbox"/>					

1.9 Treatment Setting (If the patient was not admitted to a ward in the hospital, please specify the treatment setting):

Theatre Sideroom Out-patient Dept. A&E Dept. Radiology Centre Consultant/GP Rooms Minor Injury Unit

1.10 Was the patient transferred directly from another facility for this procedure? Yes No

If yes, name other facility: _____

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: _____

2.5 Patient's Name: _____

2.3 Policy Holder's Address: _____

2.6 Patient's Date of Birth:

2.7 Contact Telephone No.: _____

2.4 Is this the Policy Holder's permanent address? Yes No

2.8 Email Address: _____

Section 3: History of Illness - for completion by the Policy Holder/Member (Please place 'X' in required boxes)

3.1 Name of doctor first attended: _____

3.2 Date of first consultation:

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?



- +
- 3.5 Has this patient had this or a similar illness before? Yes No 3.6 If Yes, please give date and details: Date:
- 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 How many **weeks** did you wait for an out-patient appointment with your consultant following your GP referral?
- 3.10 When your consultant decided that admission to hospital was necessary, how many **weeks** were you waiting for your admission?
- 3.11 Did you elect to be a private patient of the admitting consultant? Yes No
- 3.12 If transferred from a public facility, did you elect to be a private patient of the admitting consultant in that facility? Yes No
- 3.13 Is your admission/treatment related to a Clinical Research Study? Yes No

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Section 4: Injury Details - for completion in all cases involving injury (even if no third party is involved) (Please place 'X' in required boxes)

- 4.1 Date of injury: 4.2 Place of injury: _____
- 4.3 Brief description of how the injury occurred: _____
- 4.4 Do you intend to pursue a legal claim against a third party (parties)? Yes No
- 4.5 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 5: 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:

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 6: Medical History - for completion by the Admitting Consultant (Please place 'X' in required boxes)

- 6.1 Patient's Name: _____ 6.2 Are you the admitting consultant? Yes No
- If No, please state the name of the admitting consultant: _____
- 6.3 By whom was the patient referred to you? _____
- 6.4 Nature of symptoms/signs on admission: _____
- 6.5 Duration of symptoms/signs:

HOURS	DAYS	WEEKS	MONTHS	YEARS
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

 6.6 Date patient first consulted you with symptoms/signs:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y
- 6.7 Was admission: Planned Emergency 6.8 Has the patient had a previous admission for this condition? Yes No
- 6.9 Has the patient a history of this condition? Yes No 6.10 If Yes, please give date and details: Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y
- Details: _____
- 6.11 Is the admission/treatment related to a Clinical Research Study? Yes No

Section 7: Medical Investigations - for completion by the Admitting Consultant (Please place 'X' in required boxes)

- 7.1 Laboratory Investigations
- Biochemistry Histopathology Microbiology Immunology Haematology Endocrinology Other
- 7.2 If any laboratory tests were performed at another facility, please state tests and facility: _____
- 7.3 Radiology Investigations
- X-Rays Ultrasounds CT Scans MRIs PET-CTs Others
- 7.4 If any radiology investigations were performed at another facility, please state tests and facility: _____
- 7.5 Summary of key diagnostics tests performed:
-
- 7.6 Please give Clinical Indication Description and Clinical Indication Code for MRI/PET-CT Scan:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 Clinical Indicator Code:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y
- _____

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y
- 7.7 If any MRI/PET CT was performed at another facility, please state facility: _____

Section 8: Diagnosis - for completion by the Admitting Consultant (Please place 'X' in required boxes)

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

- 8.1 **Principal Diagnosis:** (*PDX = The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital*) **Vhi office use only**
- | | |
|--|----------|
| | ICD Code |
|--|----------|
- 8.2 **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*) **Vhi office use only**
- | | |
|--|----------|
| | ICD Code |
| | ICD Code |
| | ICD Code |
| | ICD Code |

- 8.3 Does this illness contain any addictive elements (alcohol, drug or other substance abuse)? Yes No
- 8.4 If Yes, and if not full stay, please indicate dates of treatment relating to addictive illness:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y





Section 9: Treatment Section - for completion by the Admitting Consultant (Please place 'X' in required boxes)

9.1 **Procedures Performed** - Please complete this section detailing surgical, diagnostic and major medical illness procedures and include Clinical Indication Code and description for Surgical Procedures.

Procedure Code: <input type="text"/>	Date of Service: <input type="text"/>	Procedure Description: _____	Anaesthesia: General <input type="text"/>	Regional <input type="text"/>	Monitored <input type="text"/>
Procedure Code: <input type="text"/>	Date of Service: <input type="text"/>	Procedure Description: _____	Anaesthesia: General <input type="text"/>	Regional <input type="text"/>	Monitored <input type="text"/>
Procedure Code: <input type="text"/>	Date of Service: <input type="text"/>	Procedure Description: _____	Anaesthesia: General <input type="text"/>	Regional <input type="text"/>	Monitored <input type="text"/>

9.2 Clinical Indicator Code(s): Clinical Indicator Description(s): _____

9.3 If drug eluting stents were used, please specify the number:

9.4 If patient was transferred to another facility for a procedure, please state procedure and facility: _____

9.5 Any unforeseen circumstances or additional information that led to an increased length of stay for this admission, including reasons for an overnight/extended admission for procedures designated as One Night Only, Day Care or Side Room: _____

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

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

START DATE END DATE

Description of treatment relating to Principal Diagnosis and Secondary Diagnoses (if any): _____

9.8 **General** - Did you personally provide the services for which you have billed? Yes No

9.9 If No, please specify who provided the treatment: _____

9.10 Did you request radiological guidance or any other consultant(s') services? Yes No

9.11 If Yes, please specify Consultant(s') name(s) in full: _____

Section 10: Discharge Status - for completion by the Admitting Consultant (Please place 'X' in required boxes)

10.1 Home Still in this hospital Transfer to another hospital Convalescence Long-term care Deceased

10.2 Is any further treatment anticipated? Yes No If Yes, please give details: _____

Section 11: Consultant 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 Consultant's Signature (You must sign here)	_____	Consultant Code: <input type="text"/>
		Date: <input type="text"/>





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.

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

Sections 6, 7, 8, 9, 10 and 11 are to be **fully** completed by the **Admitting Consultant**.

Please attach all accounts securely to the form.

This claim form should not be used to claim benefits for treatment in hospitals and treatment centres where Vhi has direct payment arrangements in place.

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) 4 444 444 or 1890 44 44 44.
Lines open 8am-6pm Monday to Friday and
9am-3pm Saturday.

Contact: Vhi.ie
Vhi.ie/contact