Maternity Claim Form

Non-Direct Payment

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

As receipt(s)/original documentation will not be returned, you may wish to retain copies prior to submission.
Copy of birth certificate(s) is sufficient to submit so that you can retain the original.

1.1 Hospital Name: _____

1.2 Hospital Address: _____

1.3 Date of Admission/Service Start Date: D D M M Y Y

1.4 Time of Admission: H H : M M

1.5 Date of Discharge/Service End Date: D D M M Y Y

1.6 Time of Discharge: H H : M M

1.7 Hospital Invoice Value: € .

1.8 Hospital Admission (Please provide details of all accommodation occupied during admission).

Type of Ward:	Please 'X'	Ward Name/Number:	Room Name/Number:	Bed Number:	Number of Beds in Room:	Number of Days:
Private Room						
Semi-Private Room						
Public Ward						

Section 2: Policy Details - for completion by the 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 Did you elect to be a private/semi-private patient of the admitting consultant? Yes ☐ No ☐

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: Inclusion of New Born Child - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

On completion of this section, your child will be insured without restriction or waiting period from date of birth.

3.1 First Name of Child:	Surname of Child:	Date of Birth:	Gender:	Relationship to Policy Holder:
_____	_____	D D M M Y Y	Male: ☐ Female: ☐	_____
_____	_____	D D M M Y Y	Male: ☐ Female: ☐	_____

3.2 Do you wish to include your child(ren) on your Vhi Hospital Policy? Yes ☐ No ☐

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

4.1 Was this a Home Birth? Yes ☐ No ☐

4.2 Have birth certificate(s) been included for your child(ren)? Yes ☐ No ☐

4.3 Number of receipts included: ☐ 4.4 Invoice Value: € ☐☐☐☐.☐☐

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: 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 6: Midwife Declaration

I hereby certify that I attended this patient for a Home Birth.

X Midwife's Signature (You must sign here) _____ Bord Altranais Registration No.: ☐☐☐☐☐☐☐

Date: D D M M Y Y

Midwife's Address _____

Section 7: Delivery Details - for completion by the Admitting/Attending Consultant (Please place '**X**' in required boxes)

7.1 Patient's Name: _____

7.2 Consultant's Name and Address: _____

Please '**X**' as appropriate: 7.3 Admission: Planned ☐ Emergency ☐ 7.4 Delivery: Vaginal ☐ C Section ☐

7.5 Date of Delivery: D D M M Y Y 7.6 Time of Delivery: H H : M M 7.7 Time of Induction: H H : M M (if applicable)

7.8 Medical reason for induction: _____

7.9 Anaesthesia: General ☐ Epidural ☐ Both ☐ 7.10 Were there any complications? Yes ☐ No ☐

7.11 Please provide details of any significant complication which led to the patient being detained in hospital: _____

_____

7.12 Has a supplementary report been provided? Yes ☐ No ☐ 7.13 Did you personally deliver the infant? Yes ☐ No ☐

Section 8: Other Services - for completion by the Admitting/Attending Consultant (Please place '**X**' in required boxes)

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

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

Section 9: Discharge Status - for completion by the Admitting/Attending Consultant (Please place '**X**' in required boxes)

9.1 Home ☐ Transfer to another hospital ☐

Section 10: Consultant Declaration

I hereby certify that the treatment specified was necessitated by the condition 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: ☐☐☐☐☐☐ Date: DD MM YY

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 completed **by the Policy Holder or Insured Member.**

Section 6 to be completed **by the Attending Midwife** when claiming benefit in relation to a home birth.

Sections 7, 8, 9 and 10 are to be completed **by the Admitting/Attending 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

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.

Contact: Vhi.ie
Vhi.ie/contact

Vhi INSURANCE

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