

MRI Claim Form

Non-Direct Payment



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

1.1 Quote Policy No. Here:

1.2 Policy Holder's Name: _____

1.5 Patient's Name: _____

1.3 Policy Holder's Address: _____

1.6 Patient's Date of Birth:

1.7 Day Time Telephone No.: _____

1.8 Evening Time Telephone No.: _____

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

1.9 Email Address: _____

Section 2: Injury Details - for completion in all cases involving injury (even if no third party is involved) (Please place 'X' in required boxes)

2.1 Date of injury:

2.2 Place of injury: _____

2.3 Brief description of how the injury occurred: _____

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

2.5 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 3: 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 1 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 4: MRI Details - for completion by the Referring Consultant/GP

4.1 Facility Name: _____

4.2 Invoice Value: €

4.3 MRI Procedure Code:

Date of Service:

Procedure description (Including anatomical site being examined): _____

MRI Procedure Code:

Date of Service:

Procedure description (Including anatomical site being examined): _____

4.4 **Clinical Indicator** Code(s): **Clinical Indicator** Description(s) for MRI Scan(s) (including, where relevant, Neurological Signs):

4.5 Clinical Interpretation of MRI Scan/Diagnosis: _____

4.6 Anaesthesia: General Regional Monitored

4.7 Reason for Anaesthesia (if provided): _____

Section 5: Referring Consultant/GP Declaration

I hereby certify that the MRI Scan specified was necessitated by the illness described by me above, and was justified by the patient's medical condition.

**X Referring Consultant/
GP Signature**
(You must sign here)

Vhi Doctor Code:

Date:

Guidelines to making a Claim

This claim form is for submitting an MRI claim, carried out at an approved MRI Centre fully covered for out-patient MRI Scans as specified in your Vhi Rules - Terms and Conditions of Membership.

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 and 3 are to be completed by the **Policy Holder or Insured Member**.

Sections 4 and 5 are to be completed by the **Referring Consultant or GP**.

Please Note

Benefits will be paid in accordance with the terms and conditions of your Vhi Plan applicable at the date the expense was incurred.

All cheques will be made payable to the Policy Holder.

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

An excess of €125 will be applied to this treatment benefit.

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

