Surgical Procedure

Direct Payment

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

1.1 **Quote Policy No. Here:** | | | | | | | | |

Hospital Code: 8 4 7

1.2 Policy Holder's Name: _____

1.3 Policy Holder's Address: _____

_____

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

1.5 Date(s) of Treatment: D D M M Y Y

1.6 Patient's Name: _____

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

1.8 Contact Telephone No.: _____

1.9 Email Address: _____

1.10 Treatment Setting: GP Surgery ☐ Consultant's Rooms ☐ Other ☐

Section 2: History of Illness - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

2.1 Name of doctor first attended: _____

2.2 Date of first consultation: D D M M Y Y

2.3 Doctor's Address: _____

2.4 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

2.5 Has this patient had this or a similar illness before? Yes ☐ No ☐

2.6 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

2.7 Are any of these expenses fully or partially recoverable from any other source? Yes ☐ No ☐

2.8 If Yes, please give details: _____

Section 3: Injury Details - for completion in all cases involving injury (even if no third party is involved) (Please place '**X**' in required boxes)

3.1 Date of injury: D D M M Y Y

3.2 Place of injury: _____

3.3 Brief description of how the injury occurred: _____

_____

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

3.5 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.

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Section 4: 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 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 5: Medical History - for completion by the Medical Practitioner (Please place '**X**' in required boxes)

5.1 Patient's Name: _____

5.2 By whom was the patient referred to you? _____

5.3 Nature of symptoms/signs: _____

_____

5.4 Duration of symptoms/signs: HOURS H H DAYS D D WEEKS W W MONTHS M M YEARS Y Y

5.5 Date patient first consulted you with symptoms/signs: D D M M Y Y

5.6 Has the patient a history of this condition? Yes ☐ No ☐ 5.7 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

5.8 Is this treatment related to a Clinical Research Study? Yes ☐ No ☐

Section 6: Diagnosis - for completion by the Medical Practitioner (Please place '**X**' in required boxes)

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

6.1 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

6.2 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

Section 7: Treatment Section - for completion by the Medical Practitioner (Please place '**X**' in required boxes)

7.1 Will you accept Vhi benefit? Yes ☐ No ☐

7.2 Procedures Performed - Please complete this section detailing procedures performed.

Procedure Code:	Date of Service:	Procedure Description:	Charge Amount:
☐☐☐☐☐	D D M M Y Y	_____	€ ☐☐☐☐.☐☐

_____

_____

Procedure Code:	Date of Service:	Procedure Description:	Charge Amount:
☐☐☐☐☐	D D M M Y Y	_____	€ ☐☐☐☐.☐☐

_____

_____

Procedure Code:	Date of Service:	Procedure Description:	Charge Amount:
☐☐☐☐☐	D D M M Y Y	_____	€ ☐☐☐☐.☐☐

_____

_____

7.3 Clinical Indicator Code(s): Clinical Indicator Description(s):

☐☐☐☐ _____

☐☐☐☐ _____

☐☐☐☐ _____

7.4 Pathology Performed: Yes ☐ No ☐

7.5 Did you personally provide the service? Yes ☐ No ☐

7.6 If No, please specify who provided the service: _____

_____

Section 8: Doctor Declaration

I hereby certify that the treatment specified was necessitated by the illness described by me above.

X Doctor's Signature
(You must sign here)

_____

Consultant Code: ☐☐☐☐☐☐

Date: D D M M Y Y

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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.

Sections 1, 2, 3 and 4 are to be **fully** completed by the **Policy Holder or Insured Member.**

Sections 5, 6, 7 and 8 are to be **fully** completed and signed **by the Admitting Doctor** who carries out the treatment.

Please forward the completed form along with the relevant invoice(s).

Direct Payment of Charges

As a service to you, Vhi and the Surgery/Clinic have a direct payment arrangement which enables your claim to be settled between the Surgery/Clinic and Vhi so that you will not be out of pocket.

All you need to do is complete **Sections 1, 2, 3 and 4** of the claim form and the Surgery/Clinic will submit the claim for you. Please do not submit bills directly to Vhi. Vhi will send you a statement of the benefits paid on your behalf.

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

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