In-patient, Day-case & Surgical Out-Patient Treatment Claim Form

In order to make a claim

Please answer all the questions below, complete the relevant sections, read and sign the declaration and consent section and ensure the original invoices are attached.

Further information

Under the 1988 Finance Act, **laya healthcare** must pay benefit for doctor's fees direct to the doctors. We will also deduct withholding tax for the Revenue Commissioners. For benefits and claim queries contact us on **1890 700 890** or **021 202 2000** or visit **www.layahealthcare.ie**. Claims should be sent by the hospital to **laya healthcare**, Eastgate Road, Eastgate Business Park, Little Island, Co. Cork

To be completed in full by the patient

1 Patient details

Membership no: ☐☐☐☐☐☐☐☐☐☐

Title:	Surname:	Forenames:

Date of birth: Day ☐☐ Month ☐☐ Year ☐☐

Address:	Telephone:

Was treatment received directly as a result of an accident? Yes ☐ No ☐ If 'Yes' please complete section 5

Did you elect to be a private patient of the Consultant? Yes ☐ No ☐

2 Hospital details

Name of the hospital you attended: Date: Day ☐☐ Month ☐☐ Year ☐☐

Address:	Telephone:

3 Symptom details

When did you/the patient first notice symptoms? Day ☐☐ Month ☐☐ Year ☐☐

When did you/the patient first consult with a doctor for this condition? Day ☐☐ Month ☐☐ Year ☐☐

Have you/the patient claimed for this or related conditions before? Yes ☐ No ☐

If Yes, when? Day ☐☐ Month ☐☐ Year ☐☐

Please provide any other relevant information:

4 Doctor's details

Name of doctor first attended: Date: Day ☐☐ Month ☐☐ Year ☐☐

Address:	Telephone:

PLEASE TURN OVER →

5 Accident section

Date of accident/injury: Day ☐☐ Month ☐☐ Year ☐☐

Description:
Place where accident/injury occurred?

How accident/injury occurred?

Was this accident/injury due to the fault of another party? Yes ☐ No ☐
If Yes; Name & Address of person, company or public body responsible?

Name of their insurance company?

Are you claiming these expenses through: Solicitor: Yes ☐ No ☐ or Personal Injuries Assessment Board: Yes ☐ No ☐

Name & address of solicitor (where applicable):

6 Declaration and consent

Data Protection Statement

The information you provide will be used to manage the administration of your policy and is held in accordance with the **Data Protection Acts** 1988 and 2003 (as amended). We may need to collect sensitive information (such as medical information) about you and others named on the insurance policy. By providing this information you will be agreeing to us or our agents or other insurers processing that information for the purpose outlined above. In the event that your treatment has involved another person, or if their details are likely to be documented in your Medical Notes/File, then their express consent should be acquired in advance of sharing sensitive data. Medical information will be kept confidential and may be disclosed, on a strictly confidential basis to those involved with your treatment or care or their health professional agents. Information may also be shared with other insurers, either directly or through people acting for the insurer such as Investigators and where we are entitled to do so under the **Data Protection Acts**. However, anonymised data – that is, information which does not identify an individual – may be used by **laya healthcare**, or disclosed to others, for research or statistical purposes. Access to non-medical information may be granted by **laya healthcare** to others on a strictly confidential basis in the course of and for the purpose of the efficient administration of **laya healthcare** (for example in connection with audit, systems development, managing and improving our services). You have a right to apply for a copy of the information held by us about you (for which a small charge, not exceeding €6.35, may apply) and you have a right to have any inaccuracies in your information corrected. Please send your request in writing to the Information Protection Manager, at **laya healthcare**, Eastgate Road, Eastgate Business Park, Little Island, Co Cork.

Declaration and Consent

I declare that at the time the expenses were incurred I/the patient was entitled to private medical insurance benefits under my/the patient's chosen **laya healthcare** scheme. I declare that my/the patient's doctor recommended the specialist treatment and to the best of my knowledge and belief the information given on this form is true and complete. I authorise and request the hospital/specialist/consultant/physician/health provider concerned to furnish **laya healthcare** or its duly authorised agents acting on its behalf (including, but not limited to, medical professionals whose services are retained by **laya healthcare** for the purpose of assessing claims) with all necessary information as **laya healthcare** or its authorised agents may seek in connection with any treatment or other services provided to me or my dependant(s) for the purpose of **laya healthcare** considering this claim. This includes copies to my/the patient's hospital/medical records in relation to this claim regarding treatment or services received by me or my dependant(s). I confirm that I have read and understood the Data Protection Notice above. I confirm that I give explicit consent within the meaning of the **Data Protection Acts** 1988 & 2003 (as amended) to my/the patient's sensitive personal information (including my/the patient's hospital/medical records) being collected by laya healthcare or its authorised agents. I confirm that I give explicit consent to this sensitive personal data being held, used and processed for the purpose of undertaking investigations into, and to adjudicate on, my/the patient's claim (including investigations into the length of my/the patient's hospital stay and the treatment I/the patient received whilst in hospital). I have examined and accept the accounts submitted in respect of this claim. Charges not eligible for benefit remain my responsibility to settle directly with the hospital and doctors concerned. I direct and authorise that all medical expenses (paid out by laya healthcare) recovered from the third party responsible for my/the patient's injuries shall be refunded by my solicitor directly to **laya healthcare**. I further direct my solicitor to deduct these amounts from my settlement cheque and reimburse **laya healthcare** directly.

✗ **Patient signature** (a parent or guardian if patient is under 16)	Date:

To be completed in full by Consultant and hospital

7 Hospital treatment section

HOSPITAL STAMP REQUIRED FOR GOVERNMENT LEVY

Date of admission: Day ☐☐ Month ☐☐ Year ☐☐ Time ☐

Date of discharge: Day ☐☐ Month ☐☐ Year ☐☐ Time ☐

Room type	Please mark with an 'X'	Ward/room	Bed number	Number of days in each bed
Private room				
Semi-Private room				
Public ward				
Day ward				
ICU / NICU / CCU				
Out-patient surgical				
Other – please specify				

Where was the procedure carried out (please tick):

☐ Consultants rooms / GP rooms	☐ Hospital theatre
☐ A&E	☐ Side room
☐ Pathology lab	☐ Minor op theatre
☐ Radiology department	☐ Other - Please specify:

To be completed by the Consultant in overall charge of the patient

8 Consultant and medical details (to be completed and signed by the Consultant in overall charge of the patient. Claim will be returned if sections 8 and 9 are not completed in full)

Nature of symptoms: ICD Code: ☐☐☐☐☐

Date you first saw patient with symptoms: Day ☐☐ Month ☐☐ Year ☐☐

Duration of symptoms prior to this: Days ☐☐ Weeks ☐☐ Months ☐☐ Years ☐☐

Have there been previous episodes of this or related symptoms? Yes ☐ No ☐

If yes, please give details:

By whom was the patient referred to you?

Was the admission: Emergency ☐ Planned ☐

Please specify medical indication which necessitated a hospital admission?

Was in-patient admission requested by GP Consultant?

a) Primary diagnosis: ICD Code: ☐☐☐☐☐

b) Secondary diagnosis: ICD Code: ☐☐☐☐☐

c) Other diagnosis: ICD Code: ☐☐☐☐☐

Please ensure that adequate and comprehensive information is provided in Nature of symptoms and Diagnosis fields. Failure to do so will result in the claim being returned without payment with a request for this information to be provided.

Full description and details of specialist investigations and/or treatment:			
Procedure code	Date of service	Anaesthesia	Procedure description
		General / Monitored	
		General / Monitored	
		General / Monitored	
		General / Monitored	

Were IV medications/IV fluids administered to the patient? Yes ☐ No ☐ Duration of infusion:

Name of drug:

Dosage: Patient weight (KG):

Procedure code:

Date of service:

If prosthesis was used, please specify the name and number:

Where a patient has a procedure with a length of stay guideline, which has become an outlier, please give the reason:

Please give the reason for hospital overnight admission where a procedure is a designated day-case procedure:

Discharge status: ☐ Home ☐ Convalescence ☐ Long-term care ☐ Deceased ☐ Transfer to another hospital

If transfer to another hospital, please specify name of hospital: Overnight admission: Yes ☐ No ☐

Is this illness related to any addictive condition? (e.g. alcohol, drug or substance abuse) Yes ☐ No ☐
If Yes, please give details:

Is this illness related to any psychiatric condition? Yes ☐ No ☐
If Yes, please give details:

Please indicate other services requested by you: ☐ Consultant ☐ Anaesthetist ☐ Pathology ☐ Radiology ☐ Other - please specify:

To be completed by the Consultant in overall charge of the patient

9 In-patient MRI / CT section (to be completed and signed by the Consultant in overall charge of the patient. Claim will be returned if sections 8 and 9 are not completed in full)

Date of scan:	Name of centre:
Procedure(s) name & code(s):	
Description of anatomical site being examined:	
Name of Consultant in overall charge:	Consultant code:
Consultant signature:	Date: Day Month Year

10 Consultant declaration

I hereby declare that the treatment I am claiming for was medically necessary, personally provided by myself and the entire length of stay was due to the medical condition indicated on this form

Name of Consultant:	**Laya Healthcare** Consultant Code
✗ **Consultant signature** (You must sign here)	Date:

 Laya Healthcare Limited is regulated by the Central Bank of Ireland.