

Maternity 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.

(For homebirths please see reverse of form - Homebirth section)

Side 1 - To be completed in full by the patient

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

1 Patient details			
Membership no:			
Title:		Surname:	
Forenames:			
Date of birth: Day		Month Year	
Telephone:			
Address:			
Did you elect to be a private patient of the Consultant? Yes ☐ No ☐			
Name and address of the hospital you attended:			
2 Doctor's details			
Name of doctor first attended:		Date: Day Month Year	
Address:		Telephone:	
3 Newborn baby details			
Your child will be added to your cover free of charge until your renewal date. No waiting periods will apply if we have been notified within 13 weeks of the babies date of birth. If you DO NOT wish your child to be added, please tick here ☐			
First name of child:	Surname of child:	Date of birth:	Gender:
		Day Month Year	Male ☐ Female ☐
		Day Month Year	Male ☐ Female ☐
		Day Month Year	Male ☐ Female ☐
4 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.			
X Patient signature (a parent or guardian if patient is under 16)		Date:	

5 Hospital treatment section

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				
Other – please specify				

6 Consultant and medical details (to be completed and signed by Consultant in overall charge of the patient. Claim will be returned if sections 6 & 7 are not completed in full)

Please give details by inserting a 'tick' in the appropriate box:

Normal delivery ☐ Caesarean section ☐ Vacuum delivery ☐ Forceps delivery ☐

Please give medical indications if Caesarean section:

Date of Delivery: Day Month Year Time of delivery

Anaesthesia General ☐ Epidural ☐ Both ☐

Please give details of any complications:

Please indicate other services which were requested by you: Consultant ☐ Pathology ☐ Radiology ☐ Other ☐
If other please specify

Did the baby require further treatment? If so, please supply details below

Did you personally provide the service billed for? Yes ☐ No ☐

Name of Consultant who delivered the baby (BLOCK CAPITALS)

7 Consultant declaration (to be completed and signed by the Consultant in overall charge of the patient)

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:

X Consultant signature
(You must sign here)

Date:

8 Homebirth section (to be completed by Midwife in overall charge of the patient)

Was the baby born at home? Yes ☐ No ☐ Date of birth: Day Month Year

Was the patient transferred to a hospital? Yes ☐ No ☐ If Yes please give details
Equipment used for homebirth please specify

Number of consultations carried out:

Cost per Consultation:

Number of receipts included:

Value of receipts:

9 Midwife declaration

I hereby certify that I attended this patient for a home birth
Name and address of attending Midwife:

Bord Altranais registration number:

X Midwife/GP signature
(You must sign here)

Date:

Claims should be sent to:

Laya healthcare, Eastgate Road, Eastgate Business Park, Little Island, Co. Cork