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



In order to make a claim  Affix Hospital Label Here
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
Claims should be sent by the hospital to <b>laya healthcare</b> , Eastgate Road, Eastgate Business Park, Little Island, Co. Cork.
Sections 1 - 6 to be completed in full by the policyholder/member
1 Policy Details
Membership no: MRN no:
Title: Surname: Forenames:
Date of birth: (DD/MM/YYYY)
Address: Telephone:
Was treatment received directly as a result of an accident? (Please place 'X' in the required box)  Yes  No  If 'Yes' please complete section 5
Did you elect to be a <b>private patient</b> of the Consultant? (Please place 'X' in the required box)  Yes  No
2 Hospital Details
Hospital Name: Date of Admission: (DD/MM/YYYY)
3 History of Illness Section
When did you/the patient first notice symptoms? (DD/MM/YYYY)
When did you/the patient first consult with a doctor for this condition? (DD/MM/YYYY)

	Referral D

Name of doctor first attended:

If yes, when? (DD/MM/YYYY)

Have you/the patient claimed for this or related conditions before? (Please place 'X' in the required box)

Date: (DD/MM/YYYY)

No

Doctor's Address:

History of Illness

### Sections 1 - 6 to be completed in full by the policyholder/member

5 Accident/Injury Section	
Date of accident/injury: (DD/MM/YYYY)	
Place where accident/injury occurred?	
How accident/injury occurred?	
Was this accident/injury due to the fault of another party? (Please place 'X' in the required box)	Yes No
If yes please provide the name & address of the person, company or public body responsible.	
Please provide the name of their insurance company?	
Are you claiming these expenses through a Solicitor: (Please place 'X' in the required box)	Yes No
Or through a Personal Injuries Assesment Board: (Please place 'X' in the required box)	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 of hospital/medical records related to a claim made by me, by which I mean the following in particular:

- records of physical or mental illness or ill-health;
- medical histories;
- records of treatments obtained by me;
- length of any stay in a hospital;
- discharge summaries;
- previous insurance details;
- other treatments or services received by me or my dependant(s); and

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. Laya Healthcare may use this information that I have provided:

- For managing and administering my insurance policy
- For underwriting and claims handling
- To analyse, examine or clinically audit the care, claims processes and treatment/ overnight-stay/convalescence/care pathway options applied/utilised by medical service providers
- · To audit medical service providers generally
- To examine the handling of claims by a medical service provider.

Medical service provider means any hospital or doctor (or other healthcare professional service which is relevant).

I confirm that I give explicit consent to this sensitive personal data being held, used and processed for the above purposes and for 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. In the event that medical expenses recovered from the third party are refunded directly to me the member I agree to refund these monies directly to laya healthcare.

Patient signature (a parent or guardian if patient is under 16)

Date: (DD/MM/YYYY)		/		/		



6	22101	
٤	Ξ	
~	7	

Sections 7 - 10 to be completed	I in full by Hospital/Consultant	in overall charge of	f the patient
Policy/Member no:	MRN no:		
7 Hospital Treatment Section			
Hospital name:			
Date of admission: (DD/MM/YYYY)	/ / / Time	•	
Date of discharge: (DD/MM/YYYY)	/	•	
Room type Please mark	with an 'X' Ward/Room	Bed Identifier	Number of days in each bed
Private room			
Semi-Private room			
Public ward			
Day ward			
ICU / NICU / CCU			
Side Room/Surgical Out-patient			
Multi-occupancy			
Single-occupancy			
Other – please specify			
Where was the procedure carried out (Please pl	ace ' <b>X</b> ' in required Boxes):		
Consultants / GP rooms	Minor op theatre		
A&E	Cath Lab		
Radiology department	Outpatient Infusion Treatment		
Hospital theatre	Other - Please specify:		
Side Room/Surgical Out-patient			
8 Consultant and Medical Details (to be of sections 8 and 9 are not completed in fi	ompleted and signed by the Consultant in oull).	verall charge of the patient.	Claim will be returned if
Was the admission: (Please place 'X' in the requ	ired box) Emergency Elective		
Is admission related to accident or injury? (Plea	se place 'X' in the required box)	No	
Please explain:			
Nature of presenting symptoms:			

<sup>\*</sup>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.

## Sections 7 - 10 to be completed in full by Hospital/Consultant in overall charge of the patient

Date you first saw patient with symptoms: (DD/MM/YYYY)	
Duration of symptoms prior to this:  Days  Weeks  Months  Years	
Have there been previous episodes of this or related symptoms? (Please place 'X' in the required box) If yes, please give details:	Yes No
By whom was the patient referred to you?	
Was in-patient admission requested by (Please place 'X' in the required box)  GP or Consult Please specify medical indication which necessitated a hospital admission?	ant
a) Primary diagnosis:	ICD 9 Code:
b) Secondary diagnosis:	ICD 9 Code:
	ICD 10 Code:
c) Other diagnosis:	ICD 9 Code:
	ICD 10 Code:
Full description and details of specialist investigations and/or treatment personally provided/being invoi  Procedure code Procedure description Date of service (DD/MM/YYYY)	Anaesthesia
Procedure code Procedure description Date of service (DD/MM/YYYY)	(Please place 'X' in the required box)
Clinical Indicator (if applicable)	General Monitored Regional
Clinical Indicator (if applicable)	General Monitored Regional
Procedure code  Clinical Indicator (if applicable)	General Monitored Regional

olicy/Member	no:					MRN no:									
Procedure  Clinical Ind (if applica	licator						//			G	Seneral	N	<b>N</b> onitore	d R	egional
f prosthesis/st	tent was used,	please sp	ecify the	name an	d serial r	number:									
Please state rea	ason for overn	ight/exter	nded adn	nission fo	r proced	ures designa	ted as One N	light Only,	Day Car	e or Sid	de Room	/Surgi	cal Out-	patient:	
here a patier	nt has a proced	lure with a	a length (	of stay gu	ideline, v	vhich has be	come an out	lier, please	give the	reasor	1:				
/here a patier	nt has a procec	lure with a	a length	of stay gu	ideline, v	vhich has be	come an out	lier, please	give the	reasor	ì:				
											1:				
	nt has a proced										ì:				
non-surgical	l cases please	outline the	ne medica	l manage	ment to s	support med	cal necessity	y for full inp	patient s		n: No				
non-surgical		outline the	ne medica	l manage	ment to s	support med	cal necessity	y for full inp	patient s	tay:	No [		Days		
non-surgical /ere IV medicate of service	l cases please ations/IV fluid	outline the	ne medica	l manage	ment to s	support med	cal necessity	y for full inp	y	tay:	No [		Days		
vere IV medicate of service	l cases please ations/IV fluid	outline the	ne medica	l manage	ment to s	support med	the required Duration of Drug Co	y for full inp d box) of infusion:	Y cable):	tay:	No [		Days		
n non-surgical	l cases please deations/IV fluid	outline the	ne medica	l manage	ment to s	support med	the required Duration of Drug Co	y for full inp d box) of infusion: de (if applic	Patient s	tay:	No [		Days		

Stay
ita
osb
Ĭ
of
: S
eta
ŏ

Is this illness related to any psychiatric condition? (Please pl If Yes, please give details:	lace 'X' in the requ	ired box)	Yes No
Please indicate other services requested by you:	ultant Anae	sthetist	Pathology Radiology Other - please specify:
If the patient was transferred to another hospital, please spe	ecify the name of tl	ne hospita	Overnight admission: Yes No
Was a procedure carried out in transfer hospital? Yes	No Pro	ocedure co	ode:
Discharge status: Home Convalescence	Long-term care	Dece	ased Transfer to another hospital
9 In-Patient MRI / CT Section (to be completed and s sections 8 and 9 are not completed in full)	signed by the Cor	nsultant i	n overall charge of the patient. Claim will be returned if
Date of scan: (DD/MM/YYYY)			Facility name:
Procedure(s) name & code(s):			
Description of anatomical site being examined:			Clinical Indicator:
Name of Consultant in overall charge:			Consultant code:
Consultant signature:			Date: (DD/MM/YYYY)
10 Consultant Declaration			
I hereby declare that the treatment I am claiming for was method the medical condition indicated on this form. I confirm that professional services.	nedically necessar t my contract of e	ry, person: mploymen	ally provided by myself and the entire length of stay was due to t with the HSE / employing authority entitles me to charge for m
Name of Consultant:			Laya Healthcare Consultant Code
Consultant signature (You must sign here)			Date: (DD/MM/YYYY)
Claim Form	Check List	Acc	ounts
Is the claim form signed by the member		Attac	th admitting consultants account
Is the membership number completed		Attac	th hospital account
Is the accident section completed		Attac	th additional accounts
Is the hospital treatment section completed (including the bed allocation)		Add	itional information if required
(including the bed allocation)			cal Report
Is the MRI section completed			
,		Lette	r for Extended Stay
Is the MRI section completed  Has the consultant completed all medical details including		Lette	

Laya healthcare must pay benefit for consultant's fees directly to consultants. Withholding tax will be deducted from benefit paid to consultants. For benefits and claim queries contact us on 1890 700 890 or 021 202 2000 or visit www.layahealthcare.ie.