General Practitioner Claim Form

laya healthcare
proudly part of AIG

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

Claims should be sent by the hospital to **laya healthcare**, Eastgate Road, Eastgate Business Park, Little Island, Co. Cork, T45 E181.

Sections 1 - 4 to be completed in full by the policyholder/member

Policy Details

1 Policy Details

Membership 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 3

History of Illness

2 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)

Have you/the patient claimed for this or related conditions before? (Please place 'X' in the required box) Yes ☐ No ☐

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

Accident/Injury Details

3 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):

Member Authorisation/Declaration & Consent

4 Declaration

Data Protection Statement

"**Personal Information**" identifies and relates to you or other individuals (e.g. your partner or other members of your family). If you provide Personal Information about another individual, you must (unless we agree otherwise) inform the individual about the content of this notice and our Privacy Policy and obtain their permission (where possible) to share their Personal Information with us. Depending on our relationship with you, Personal Information collected may include: contact information, financial information and account details, sensitive information about health or medical conditions (collected with your consent where required by applicable law) or (where we require it and are legally permitted to collect it). Personal Information may be used for the following purposes:

- Insurance administration, e.g. communications, claims processing and payment
- Assessments and decisions about the provision and terms of insurance and the settlement of claims including but not limited to: a) analyse, examine or clinically audit the care, claims processes and treatment/ overnight-stay/ convalescence /care pathway options applied/utilised by medical service providers; b) to undertake investigations into, and to adjudicate on, patient's claim (including investigations into the length of the patient's hospital stay and the treatment received whilst in hospital)
- Assistance and advice on medical and travel matters
- Management of our business operations and IT infrastructure
- Prevention, detection and investigation of crime, e.g. fraud and money laundering
- Establishment and defence of legal rights
- Legal and regulatory compliance (including compliance with laws and regulations outside your country of residence)
- Monitoring and recording of telephone calls for quality, training and security purposes
- Audit of medical service providers and the handling of claims by a medical services provider
- Marketing, market research and analysis

For the above purposes, Personal Information may be shared with our group companies and third parties (such as insurance distribution parties, healthcare professionals and other service providers). Personal Information will be shared with other third parties (including government authorities) if required by laws or regulations. Appropriate technical and physical security measures are used to keep your Personal Information safe and secure.

When we provide Personal Information to a third party (including our service providers) or engage a third party to collect Personal Information on our behalf, the third party will be selected carefully and required to use appropriate security measures. You have a number of rights under data protection law in connection with our use of your Personal Information. These rights may only apply in certain circumstances and are subject to certain exemptions. These rights may include a right to access Personal Information, a right to request that we correct inaccurate data, erase data, or suspend our use of data. These rights may also include a right to transfer your data to another organisation, a right to object to our use of your Personal Information, a right to request that certain automated decisions we make have human involvement, a right to withdraw consent and a right to complain to the data protection regulator in your country. Further information about your rights and how you may exercise them is set out in full in our Privacy Policy (see below). More details about your rights and how we collect, use and disclose your Personal Information can be found in our full Privacy Policy which is available at https://www.layahealthcare.ie/privacypolicy or upon request by writing to Privacy Lead, LayaHealthcare, Eastgate Road, Eastgate Business Park, Little Island, Co Cork, T45 E181 or by emailing info@layahealthcare.ie

Declaration

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.

For the purpose of considering and determining the eligibility/ appropriateness of claims **laya healthcare** may 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**) with all necessary information as **laya healthcare** or its authorised agents may seek in connection with any treatment or other services provided to you or your dependant(s). This includes copies of hospital/ medical records related to a claim made by you or your dependant(s), by which I mean the following in particular:

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

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**.

Print name

Signature (a parent or guardian if patient is under 16)

Date: (DD/MM/YYYY) / /

Sections 5 - 6 to be completed in full by GP in overall charge of the patient

Policy/Member no:

Symptoms

5 GP and Medical Details (to be completed and signed by the GP in overall charge of the patient. Claim will be returned if sections 5 and 6 are not completed in full).

Is treatment related to accident or injury? (Please place 'X' in the required box) Yes No

Please explain:

Nature of presenting symptoms:

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) Yes No

If yes, please give details:

*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.

Diagnosis

a) Primary diagnosis:

b) Other diagnosis:

Procedures

Full description and details of specialist investigations and/or treatment personally provided/being invoiced:

Procedure code	Procedure description	Date of service (DD/MM/YYYY)
Clinical Indicator (if applicable)		
Procedure code	Procedure description	Date of service (DD/MM/YYYY)
Clinical Indicator (if applicable)		

Medical Management

Pathology Performed? Yes ☐ No ☐

6 GP Declaration

I hereby declare that the treatment I am claiming for was medically necessary, personally provided by myself. I confirm that my contract of employment with the HSE / employing authority entitles me to charge for my professional services.

Name of GP:

Laya Healthcare GP Code

GP signature
(You must sign here)

X

Date: (DD/MM/YYYY)

Claim Form	Check List
Is the claim form signed by the member	☐
Is the membership number completed	☐
Is the accident section completed	☐

Claim Form	Check List
Has the GP completed all medical details including diagnosis and onset date of symptoms	☐
Is the invoice attached?	☐
Is the claim form signed by the GP	☐

Further information

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

Your claim will not be processed if any of the following is not included:

Invoice	☐
Member Signature	☐
GP Signature	☐
Symptoms	☐
Diagnosis	☐
Schedule of Benefit Requirements	☐

Procedure Codes* with Schedule of Benefit requirements:

Procedure code 16- Phlebotomy:

CLINICAL INDICATORS MUST BE NOTED ON THE CLAIM FORM:

(0222) Haemochromatosis (including hereditary haemochromatosis) where there is evidence of Iron overload with an initial serum ferritin of 300 µg per litre in males and 200µg per litre in females

(0223) Polycythaemia vera; primary

(0224) Polycythaemia secondary EPO-mediated, including:
i. Central hypoxia e.g. chronic lung disease, right to left cardiopulmonary vascular shunts or
ii. Local renal hypoxia e.g. renal artery stenosis, end-stage renal failure or
iii. Pathologic EPO production e.g. Hepatocellular carcinoma, renal cell carcinoma, pheochromocytoma or
iv. Exogenous EPO, drug associated e.g. post renal transplant erythrocytosis, idiopathic erythrocytosis
INITIAL SERUM FERRITIN FOR CLINICAL INDICATOR (0222) AND THE INITIAL HCT FOR CLINICAL INDICATORS (0223 & 0224) REQUIRED ON THE THE FIRST CLAIM

Procedure code 29- Basal cell carcinoma/squamous cell carcinoma, simple excision:

HISTOLOGY REPORT REQUIRED WITH THE CLAIM FORM

Procedure codes-44/51 – Cryosurgery/cryotherapy of warts:

SITE OF WARTS MUST BE SPECIFIED ON THE CLAIM FORM

Procedure code 69- Biopsies of the skin, subcutaneous tissue and/or mucous membrane including simple closure:

AREAS BIOPSIED MUST BE SPECIFIED ON THE CLAIM FORM

*Full listing of Procedure codes/Procedure codes with additional requirements are available on the schedule of benefits. You can view the Schedule of Benefits online by logging in to our Consultant Area at https://www.layahealthcare.ie/consultantlogin