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

laya healthcare

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.

Affix Hospital Label Here

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

Policy Details

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 **private patient** of the Consultant? (Please place 'X' in the required box) Yes ☐ No ☐

Hospital

2 Hospital Details

Hospital Name: | Date of Admission: (DD/MM/YYYY)

History of Illness

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)

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)

Referral

4 Referral Details

Name of doctor first attended: | Date: (DD/MM/YYYY)

Doctor's Address:

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

Accident/Injury Details

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):

Member Authorisation/Declaration & Consent

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) | | | / | | | / | | | | |

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

Policy/Member no: | | | | | | | | | | | MRN no: | | | | | | | | | | |

Admission

7 Hospital Treatment Section

Hospital name:

Date of admission: (DD/MM/YYYY) | | | / | | | / | | | | | Time | | | : | |

Date of discharge: (DD/MM/YYYY) | | | / | | | / | | | | | Time | | | : | |

Accommodation

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 place '**X**' 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	

Symptoms

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).

Was the admission: (Please place 'X' in the required box) Emergency Elective

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

Please explain:

Nature of presenting symptoms:	

*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.

PLEASE TURN OVER

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

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:

Diagnosis

By whom was the patient referred to you?

Was in-patient admission requested by (Please place 'X' in the required box) GP ☐ or Consultant ☐

Please specify medical indication which necessitated a hospital admission?

a) Primary diagnosis:	ICD 9 Code: ☐☐☐☐☐☐ ICD 10 Code: ☐☐☐☐☐☐☐
b) Secondary diagnosis:	ICD 9 Code: ☐☐☐☐☐☐ ICD 10 Code: ☐☐☐☐☐☐☐
c) Other diagnosis:	ICD 9 Code: ☐☐☐☐☐☐ ICD 10 Code: ☐☐☐☐☐☐☐

Procedures/Anaesthesia

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

Procedure code	Procedure description	Date of service (DD/MM/YYYY)	Anaesthesia (Please place 'X' in the required box)
☐☐☐☐☐ Clinical Indicator (if applicable) ☐☐☐☐☐		☐☐/☐☐/☐☐☐☐	☐ General ☐ Monitored ☐ Regional
Procedure code ☐☐☐☐☐ Clinical Indicator (if applicable) ☐☐☐☐☐		☐☐/☐☐/☐☐☐☐	☐ General ☐ Monitored ☐ Regional
Procedure code ☐☐☐☐☐ Clinical Indicator (if applicable) ☐☐☐☐☐		☐☐/☐☐/☐☐☐☐	☐ General ☐ Monitored ☐ Regional

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

Policy/Member no: MRN no:

Procedures/Anaesthesia

Procedure code			
		/ /	General Monitored Regional
Clinical Indicator (if applicable)			

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

Please state reason for overnight/extended admission for procedures designated as One Night Only, Day Care or Side Room/Surgical Out-patient:

Medical Management

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

In non-surgical cases please outline the medical management to support medical necessity for full inpatient stay:

Pharmacotherapy

Were IV medications/IV fluids administered to the patient? (Please place 'X' in the required box) Yes No

Date of service: (DD/MM/YYYY) / / Duration of infusion: Hours Days

Name of drug: Drug Code (if applicable):

Dosage: Patient weight (KG):

Name of drug: Drug Code (if applicable):

Dosage: Patient weight (KG):

Is this illness related to any addictive condition? (e.g. alcohol, drug or substance abuse) (Please place 'X' in the required box) Yes No
If Yes, please give details:

Details of Hospital Stay

Is this illness related to any psychiatric condition? (Please place 'X' in the required box) Yes ☐ No ☐
If Yes, please give details:

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

If the patient was transferred to another hospital, please specify the name of the hospital:

Overnight admission: Yes ☐ No ☐

Was a procedure carried out in transfer hospital? Yes ☐ No ☐ Procedure code: ☐☐☐☐☐

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

CT/MRI

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: (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 medically necessary, personally provided by myself and the entire length of stay was due to the medical condition indicated on this form. I confirm that my contract of employment with the HSE / employing authority entitles me to charge for my professional services.

Name of Consultant:

Laya Healthcare Consultant Code ☐☐☐☐☐

Consultant 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	☐
Is the hospital treatment section completed (including the bed allocation)	☐
Is the MRI section completed	☐
Has the consultant completed all medical details including diagnosis and onset date of symptoms	☐
Have other services provided been mentioned by the consultant	☐
Is the claim form signed by the consultant	☐

Accounts	
Attach admitting consultants account	☐
Attach hospital account	☐
Attach addtional accounts	☐
Additional information if required	
Medical Report	☐
Letter for Extended Stay	☐
Discharge Summary	☐

Further information

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**.