looking after you always

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

Affix Hospital Label Here

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

1 Policy Details

Membership no:

MRN no (for hospital use only):

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

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)

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)

4 Referral Details

Name of doctor first attended:

Date: (DD/MM/YYYY)

Doctor's Address:

PLEASE TURN OVER

part of AXA

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

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.

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 7 - 10 to be completed in full by Hospital/Consultant in overall charge of 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) | | | / | | | / | | | | | Time | | | : | | |

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	

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.

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) Yes No

If yes, please give details:

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:

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: | | | | | | | | | | |

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:

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:

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:

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

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)
✗

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 **021 202 2000** or visit **www.layahealthcare.ie**.

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