

Direct payment of medical charges

To make sure that you are not out of pocket, VIVAS Health and most hospitals have a direct payment agreement that enables your claim to be settled directly between the hospital and VIVAS Health. To facilitate this, VIVAS Health may provide information to the hospital verifying your membership eligibility. All you need to do is complete Part 1 of the claim form and the hospital will submit the claim for you. Please do not submit bills and claims directly to VIVAS Health, unless the hospital does not have direct payment. We will send you a statement of the benefits paid on your behalf.

IF YOU HAVE AN OUT PATIENT CLAIM PLEASE CALL 1850 717 717 AT THE END OF YOUR POLICY YEAR

Part 1 – This is to be completed by the Patient and/or the Policyholder:

Patient's name: _____ Patient's membership number: _____
 Patient's relationship to policyholder: _____
 Daytime contact number or mobile of patient: _____ Patient's date of birth (day/mth/yr): _____
 Was treatment received directly as a result of an accident? Yes No
 Did you elect to be a private patient of the admitting consultant? Yes No

History of illness section

Please complete this section in full:

When did you first suffer from these symptoms or illness? (/ /) _____
 When did you first visit your doctor with these symptoms? (/ /) _____
 Name of doctor first attended: _____
 Full address of doctor first attended: _____

 Telephone number of doctor first attended: _____
 Have you ever made a claim for this or any other similar condition in the past with VIVAS Health or any other insurer? Yes No
 If yes, please supply details of where and when: _____

Third party claims

This section is for completion where you are making a claim against a third party (another person, company or public body or where another person was responsible for your injury).

Name of person, company or public body responsible: _____
 Address of person, company or public body responsible: _____
 Name of insurance company: _____
 Name of solicitor: _____
 Contact name: _____
 Solicitor's address in full: _____

 Personal Injuries Assessment Board contact name: _____

Personal injury claims

This section is for completion in the case of personal injury.

Date of occurrence of injury (day/mth/yr): _____
 Place of injury: _____
 Brief description of how injury occurred: _____

Third party assignment

In consideration of VIVAS Health discharging my hospital and medical expenses to the extent of cover limits, I undertake to VIVAS Health to include these expenses as part of my claim against a third party and to inform my solicitor or Personal Injury Assessment Board to this effect when pursuing any claim.

Consent

I declare that at the time I underwent medical treatment I was a party to a health insurance contract and was entitled to treatment under my VIVAS Health plan. I declare that my doctor, including accident and emergency referral, recommended the treatment and referred me to the appropriate consultant for further treatment. I declare that to the best of my knowledge, the information provided in Part 1 of this form is accurate, true and complete. I authorise the doctors/consultant/hospital to furnish VIVAS Health, or any authorised agent it may appoint to act on its behalf, with any information requested, including access to my hospital/medical records, where this is necessary in relation to any claim regarding treatment or services received by me or my named dependents. I authorise the direct payment by VIVAS Health to the doctors/consultant/hospital as appropriate for the services set out on this claim form to the extent provided for under my VIVAS Health plan. I verify the details of the accounts submitted on my behalf by the doctor/hospital/consultant as an accurate reflection of the treatment I received. I understand that the details of these amounts will be included in my VIVAS Health statement of payment and I will have the opportunity to contact VIVAS Health directly with any queries. Charges not covered under the VIVAS Health plan to which I subscribe will remain my responsibility or that of the named dependent who received the treatment to settle directly with the doctors, consultant or hospital concerned.

Signature of patient: _____
 Date: _____

Data Protection Act 1988 as amended

The information you provide becomes part of the personal data held by VIVAS Health and will be automated. All your personal data is confidential and will be used only for the provision and administration of health insurance products and related services. The public register of the Data Protection Commissioner holds full details of all uses of personal data by VIVAS Health.

VIVAS Health, PO Box 9686, Foxrock, Dublin 18.
 1850 717 717 www.vivashealth.ie

VIVAS Insurance Limited, trading as VIVAS Health, is regulated by Financial Regulator.

Part 2 – This part to be completed in full by the admitting doctor/consultant/GP.
Consultant and medical section

Patient's full name: _____

Please state the name of the person who referred patient to you: _____

 Was the admission an emergency? Yes No

 Was this a re-admission for the same condition? Yes No

Nature of symptoms: _____

Duration of symptoms: _____

When did the patient first consult you with these symptoms? _____

Reason for admission (admitting diagnosis): _____

Date of treatment: (day/mth/yr) _____

Primary diagnosis: _____

Secondary diagnosis: _____

Please supply full description and details of tests/treatment supplied covered by this claim: _____

Please supply procedure name and applicable code: _____

 Has the patient a history of these or any related symptoms? Yes No

If yes, please give the details and dates of the treatments prior to these admissions: _____

 Is the admission/treatment related to a clinical research study? Yes No

 Was the patient transferred from the hospital during this visit for any other investigations? Yes No

If Yes, please supply name of the hospital and nature of test/treatment performed: _____

 Is this claim related to any addictive condition? (eg. alcohol dependence, drugs or other substance abuse) Yes No

If yes, please give details: _____

 Is this claim related to any psychiatric condition? Yes No

If yes, please give details: _____

Is any further treatment required? _____

 Was patient transferred on discharge to a nursing/convalescence home by you? Yes No

If yes, please supply details: _____

Consultant signature: _____

Date: _____

Doctor code: _____

Please attach relevant receipts.

Scans - Out patient only
This section is for completion in the case of scans only

Which hospital/approved centre carried out the scan? _____

Date of MRI/CT/PET* scan: (day/mth/yr) _____

Reason for referral: _____

MRI/CT procedure codes: _____

Consultant signature: _____

Date: _____

Doctor code: _____

Please attach relevant receipts.

*Requires pre-certification from VIVAS Health

Part 3 – Hospital details
This part to be completed in full by the hospital.

Name of hospital/place of treatment: _____

Date of admission: (day/mth/yr): _____

Date of discharge: (day/mth/yr): _____

Please indicate type of stay:

 Private in patient Semi-private in patient Day case in a hospital

 Procedure/ treatment in an out patient department Public ward

Hospital stamp: _____

Hospital code: _____

Please attach bill with relevant procedure code