# Surgical Procedure

Direct Payment

## Section 1: Policy/Treatment Details - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

1.1 **Quote Policy No. Here:** | | | | | | | | |  Hospital Code: 8 4 7

1.2 Policy Holder's Name: _____

1.3 Policy Holder's Address: _____

_____

1.4 Is this the Policy Holder's permanent address? Yes ☐ No ☐

1.5 Date(s) of Treatment: D D M M Y Y

1.6 Patient's Name: _____

1.7 Patient's Date of Birth: D D M M Y Y

1.8 Contact Telephone No.: _____

1.9 Email Address: _____

1.10 Treatment Setting: GP Surgery ☐ Consultant's Rooms ☐ Other ☐

## Section 2: History of Illness - for completion by the Policy Holder/Member (Please place '**X**' in required boxes)

2.1 Name of doctor first attended: _____

2.2 Date of first consultation: D D M M Y Y

2.3 Doctor's Address: _____

2.4 When was it first made known to you that this particular investigation/treatment (which is the subject of this claim) was required? D D M M Y Y

2.5 Has this patient had this or a similar illness before? Yes ☐ No ☐

2.6 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

2.7 Are any of these expenses fully or partially recoverable from any other source? Yes ☐ No ☐

2.8 If Yes, please give details:

_____

## Section 3: Injury Details - for completion in all cases involving injury (even if no third party is involved) (Please place '**X**' in required boxes)

3.1 Date of injury: D D M M Y Y

3.2 Place of injury: _____

3.3 Brief description of how the injury occurred: _____

_____

3.4 Do you intend to pursue a legal claim against a third party (parties)? Yes ☐ No ☐

3.5 Name and address of solicitor (where applicable):

_____

In consideration of Vhi Healthcare discharging my hospital and medical expenses to the extent of my cover limits and in accordance with the Rules of my contract with Vhi Healthcare, I undertake to Vhi Healthcare to include these expenses as part of my current (or future) claim against a third party(ies). Where I pursue a claim against a third party, either through the Courts or other Tribunals/Boards (and where I have legal representation), I hereby irrevocably authorise the solicitor(s) representing me in making that claim to furnish to Vhi Healthcare an undertaking in the following form: "In consideration of Vhi Healthcare discharging the eligible hospital and medical expenses of my/our client, I/we hereby undertake to include as part of my/our client's claim the monies so paid by Vhi Healthcare (details of which will be supplied to us by Vhi Healthcare) and subject to any court order to the contrary, to repay to Vhi Healthcare – out of the proceeds that come into our hands – all such monies paid by Vhi Healthcare ". Where my claim is adjudicated upon by the Personal Injuries Assessment Board (PIAB) or the Criminal Injuries Compensation Tribunal and where I do not engage legal representation, I hereby undertake to include as part of my claim the monies so paid by Vhi Healthcare (details of which will be supplied to me by Vhi Healthcare) and subject to any order/award to the contrary, to repay to Vhi Healthcare – out of the proceeds that come into my hands – all such monies paid by Vhi Healthcare. I further authorise Vhi Healthcare to provide PIAB with details of all monies paid by Vhi Healthcare relating to my application and for PIAB to release to Vhi Healthcare details of their assessment in relation to the monies paid by Vhi Healthcare.

**X Signature:**
Injured Member (if over 18)

_____

**X Policy Holder's Signature:**
(if under 18)

_____

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## Section 4: Policy Holder/Member Authorisation

I declare that the foregoing statements are true in every respect. I authorise the doctor(s) concerned to supply all necessary information to Vhi Healthcare including, if requested, copies of my hospital/medical records. I also authorise Vhi Healthcare to pay the appropriate benefits for services provided to the doctor(s) concerned. I understand that details of these amounts will be included in my Vhi Healthcare statement of payment, and I will contact Vhi Healthcare directly with any queries. Charges which are not eligible for benefit will remain my responsibility to settle directly with the doctor(s) concerned.

**X Policy Holder's/Member's Signature** (You must sign here) _____ Date: D D M M Y Y

Please check that you have entered your Policy Number

DATA PROTECTION NOTICE - The information you provide becomes part of the personal data held by Vhi Healthcare and is automated. It is used for the payment of claims and for the provision and administration of health insurance products and related services. Full details of the Vhi Healthcare's use of personal data appear in the public register held by the Data Protection Commissioner. If you have any enquiries about your data, please write to the Data Manager, Vhi Healthcare, IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.

## Section 5: Medical History - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

5.1 Patient's Name: _____

5.2 By whom was the patient referred to you? _____

5.3 Nature of symptoms/signs: _____

5.4 Duration of symptoms/signs: HOURS H H DAYS D D WEEKS W W MONTHS M M YEARS Y Y

5.5 Date patient first consulted you with symptoms/signs: D D M M Y Y

5.6 Has the patient a history of this condition? Yes ☐ No ☐

5.7 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

5.8 Is this treatment related to a Clinical Research Study? Yes ☐ No ☐

## Section 6: Diagnosis - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

6.1 Please list primary, secondary and other diagnoses, indicating whether acute, sub-acute or chronic:

Primary Diagnosis: _____

Secondary/Other Diagnoses: _____

## Section 7: Treatment Section - for completion by the Admitting Consultant (Please place '**X**' in required boxes)

7.1 Will you accept Vhi Healthcare benefit? Yes ☐ No ☐

7.2 Procedures Performed - Please complete this section detailing procedures performed.

| Procedure Code: | Date of Service: | Procedure Description: | Charge Amount: |
|---|---|---|---|
| | D D M M Y Y | | € . |
| | D D M M Y Y | | € . |
| | D D M M Y Y | | € . |

7.3 Pathology Performed: Yes ☐ No ☐

7.4 Did you personally provide the treatment? Yes ☐ No ☐

7.5 If No, please specify who provided the treatment: _____

## Section 8: Doctor Declaration

I hereby certify that the treatment specified was necessitated by the illness described by me above.

**X Doctor's Signature** (You must sign here) _____ Doctor Code: Date: D D M M Y Y

## Guidelines to making a Claim

It would help us give you a speedier service and keep down administration costs if you could observe these guidelines when submitting a claim.

**Sections 1, 2, 3 and 4** are to be **fully** completed by the **Policy Holder or Insured Member**.
**Sections 5, 6, 7 and 8** are to be **fully** completed and signed **by the Admitting Doctor** who carries out the treatment.
Please forward the completed form along with the relevant invoice(s).

**Direct Payment of Charges**

As a service to you, Vhi Healthcare and the Surgery/Clinic have a direct payment arrangement which enables your claim to be settled between the Surgery/Clinic and Vhi Healthcare so that you will not be out of pocket.

All you need to do is complete **Sections 1, 2, 3 and 4** of the claim form and the Surgery/Clinic will submit the claim for you. Please do not submit bills directly to Vhi Healthcare. Vhi Healthcare will send you a statement of the benefits paid on your behalf.

**Direct Payment of benefit towards professional fees to doctors**

Under the Finance Act, 1988, Vhi Healthcare is required to pay benefit in respect of doctors' fees direct to the doctors concerned. We are also required to deduct Withholding Tax from these payments and remit it to the Revenue Commissioners. This does not, in any way, affect or reduce the value of your Vhi Healthcare cover.

As the costs of consultant treatment vary, we advise you to obtain an estimate of all the likely professional fees before treatment begins.

## Claim Form Submission Address: Vhi Healthcare, PO Box 10143, Dublin 18.

| | | |
|---|---|---|
| **Dublin:** | Vhi House, Lower Abbey Street, Dublin 1. | Fax: (01) 799 4091 |
| **Cork:** | Vhi House, 70 South Mall, Cork. | Fax: (021) 427 7901 |
| **Dun Laoghaire:** | 35/36 Lower George's Street, Dun Laoghaire. | Fax: (01) 619 7456 |
| **Galway:** | Vhi House, 10 Eyre Square, Galway. | Fax: (091) 564 307 |
| **Kilkenny:** | IDA Business Park, Purcellsinch, Dublin Road, Kilkenny. | Fax: (056) 776 1741 |
| **Limerick:** | Gardner House, Charlotte Quay, Limerick. | Fax: (061) 310 361 |

QUALITY ISO 9001:2008 NSAI Certified

**Office opening hours:** 10am-4pm Monday to Friday.

**Tel:** LoCall 1890 44 44 44.
Lines open 8am-6pm Monday to Friday and 9am-3pm Saturday.

**Website:** www.vhi.ie **E-mail:** info@vhi.ie

Vhi HEALTHCARE