

laya
healthcare

Further information

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

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

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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 Assessment 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

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:

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?

Diagnosis

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:

Procedures/Anaesthesia

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
Clinical Indicator (if applicable)		/ /	☐ General ☐ Monitored ☐ Regional
Clinical Indicator (if applicable)		/ /	☐ General ☐ Monitored ☐ Regional

[illegible][illegible][illegible]

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

Yes ☐ No ☐

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		Hours				Days
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Yes ☐ No ☐

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 additional 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.