Irish Life health

Maternity Claim Form
Direct Payment of Medical Charges

To make sure that you are not out of pocket, Irish Life Health and most hospitals have a direct payment agreement that allows your claim to be settled directly between the hospital and Irish Life Health. To facilitate this, Irish Life Health may provide information to the hospital verifying your membership eligibility. All you need to do is complete Part 1 of the claim form, sign at the bottom of page 2 and the hospital will submit the claim for you. Please do not submit bills and claims directly to Irish Life Health, unless the hospital does not have direct payment. We will send you a statement of the benefits paid on your behalf. **Failure to complete the claim form correctly may result in the return of the claim in its entirety.**

On some of our plans, your child can be added to your cover, free of charge, until your next renewal date. Please contact us on 1850 717 717 to arrange this cover.

PART 1 This part to be completed by the Patient and/or the Policy Holder.

Patient's name: ....

Patient's membership number:* ☐☐☐☐☐☐☐☐☐☐

Daytime contact number or mobile of patient: ....

Patient's date of birth (dd·mm·yy): ☐☐·☐☐·☐☐

Patient's relationship to policyholder: ....

Did you elect to be a private patient of the admitting consultant? Yes ☐ No ☐

*This can be found on your membership card and on your membership certificate

Home Births

If the birth was a home birth, please complete this section.

Date of delivery (dd·mm·yy): ☐☐·☐☐·☐☐

Name and address of the attending midwife/GP: ....

Midwife's Bord Altranais registration number: ☐☐☐☐☐☐☐☐☐☐

Please attach relevant receipts.

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 Irish Life Health plan. Ideclare 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 Irish Life 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 dependants. I authorise the direct payment by Irish Life Health to the doctors/consultant/hospital as appropriate for the services set out on this claim form to the extent provided for under my Irish Life 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 Irish Life Health statement of payment and I will have the opportunity to contact Irish Life Health directly with any queries. Charges not covered under the Irish Life Health plan to which I subscribe will remain my responsibility or that of the named dependant who received the treatment to settle directly with the doctors, consultant or hospital concerned. In consideration of Irish Life Health discharging my hospital and medical expenses to the extent of cover limits, I undertake to Irish Life 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.

Declaration

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the Data Protection section on **page two** of this form.

Your signature: ....

Date: ....

Please turn over

PART 2 Maternity Consultant Section

Patient's full name: Procedure code:

Vaginal Delivery: Yes ☐ No ☐ If Yes, please specify if: Spontaneous ☐ Instrument Assisted ☐ Vacuum Assisted ☐

Caesarean Section: Yes ☐ No ☐

Did any complications exist throughout the pregnancy? Hypertension ☐ High Risk Pregnancy ☐ None ☐ Other ☐ Please Specify details:

Date of delivery (dd·mm·yy): *Please confirm if you personally attended the delivery: Yes ☐ No ☐

Did the patient require ICU services? Yes ☐ No ☐

If yes, please confirm days spent on mechanical ventilation?

Type of anaesthesia administered: General ☐ Monitored ☐ Regional ☐ Epidural ☐ No Anaesthesia ☐

Please confirm if delivery resulted in: Single birth ☐ Twin birth ☐ Multiple Birth ☐

Birth weight of new born:

Consultant signature: Date (dd·mm·yy):

Irish Life Health Doctor Code:

*This can be found on your membership card and on your membership certificate

PART 3 Hospital Details

This part to be completed in full by the hospital.

Name of hospital/place of treatment:

MRN Number: Episode / Account Number:

Date of admission (dd·mm·yy): Date of discharge (dd·mm·yy):

Time of admission (hh·mm): Time of discharge (hh·mm):

Discharge Status: Home ☐ Still in hospital ☐ Transfer to another hospital ☐

Room Type	Please Mark with an 'X'	Ward/Room Name/No.	Bed No.	No. Days in Each Bed
Private room				
Semi-private room				
Public room				

Total number of days the patient did not occupy the above bed(s) during this admission:

Hospital stamp: Hospital code:

Please attach bill with relevant procedure code.

Data Protection

Irish Life Health dac is registered with the Office of the Data Protection Commissioner to act as a data controller and data processor in relation to the personal information held about you and any other member named on your policy.

The personal information that you have provided to us or that we otherwise obtain in connection with your policy will be used to administer your policy and other insurance products provided by us, other companies in the Irish Life Group or other commercial partners, in accordance with data protection and other applicable legislation and the Office of the Data Protection Commissioner-approved Code of Practice on Data Protection for the Insurance Sector. Please do not send us any genetic test results.

We will share this information with our third party administrators and any other commercial entity for the purposes above and as required to provide our services and in order to comply with legal obligations imposed on us. We may share and use this information both inside and outside of the European Economic Area, in confidence, for these purposes. We may in certain circumstances either directly or indirectly share your personal information with other insurers for the purposes of verifying information and determining waiting periods and with insurance bodies to the extent permitted by law. If you give us false information or fail to disclose information, we will record this.

To help improve the level of service we provide, we may on occasions contact you for participation in consumer satisfaction or research surveys. Your details may be used for these purposes for 12 months after your policy has ceased.

Important: In certain instances, we may need to collect personal information, including medical or other sensitive personal information, from third parties about you and any other member named on your policy. This information will remain strictly confidential and will only be sought and used in order to provide the services set out in your contract with us and for administration of this policy. By entering into a new policy with us, or renewing or amending an existing policy with us, you are also confirming that where relevant, each member of the policy has reviewed this notice and given their consent for the disclosure to us and the use of their personal information (including information collected from third parties) in the manner and for the purposes set out in this notice.

ONLY SIGN THE DECLARATION OVERLEAF IF YOU FULLY UNDERSTAND AND HAVE MET ALL OF THE ABOVE REQUIREMENTS.

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