

For Maternity claims

(For homebirths please see reverse of form - Homebirths section)

Claim Form



USING THIS CLAIM FORM

This claim form has been designed to help you make a claim from us for maternity and homebirth claims. If you have any queries about your benefits or how to make a claim please contact us on 1890 700 890 or visit www.quinn-healthcare.com.

IN-PATIENT, DAY-CASE, POST-NATAL AND SURGICAL OUT-PATIENT CLAIMS

If you wish to make a claim for in-patient, day-case, post-natal or surgical out-patient treatment please ask us for a separate claim form.

SUBMITTING YOUR CLAIM

- Check the member's section is fully completed
- Check the medical section is fully completed
- Check all relevant sections have been signed - both by the QUINN-healthcare member and the patient's consultant
- Check that the original accounts are attached
- If you require copies of accounts please let us know when you submit your claim.

IN ORDER TO MAKE A CLAIM

- Please ensure that all relevant sections of the claim form are fully completed.
- Always enclose the original accounts - photocopies, receipts etc. are not acceptable.

CLAIMS SHOULD BE SENT TO:

QUINN-healthcare, Mill Island, Fermoy, Co. Cork.

1 Member's section				
Membership no	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Title	Surname	Forenames		
Date of birth	Day <input type="text"/> <input type="text"/>	Month <input type="text"/> <input type="text"/>	Year <input type="text"/> <input type="text"/>	Telephone
Correspondence address				
2 Patient details (if any different from above)				
Membership no	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Title	Surname	Forenames		
Date of birth	Day <input type="text"/> <input type="text"/>	Month <input type="text"/> <input type="text"/>	Year <input type="text"/> <input type="text"/>	Telephone
3 Doctor details				
Name of doctor first attended				
Telephone				
Address				
4 Declaration and consent				
<p>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 QUINN-healthcare scheme. I declare that my/the patient's doctor recommended the specialist treatment and that to the best of my knowledge and belief the information given on this form is true and complete.</p> <p>I authorise and request any hospital, specialist, physician or other health provider to furnish QUINN-healthcare or it's duly authorised agent acting on QUINN-healthcare's behalf with such information as QUINN-healthcare or that agent may seek from them in connection with any treatment or other services provided to me or my dependant for the purpose of QUINN-healthcare considering this claim. I have examined and accept the accounts submitted in respect of this claim. Charges not eligible for benefit remain my responsibility to settle direct with the hospital and doctors concerned.</p>		<p>DATA PROTECTION ACT 1988</p> <p>You should show this notice to anyone who may be covered by your insurance policy with QUINN-healthcare.</p> <p>All personal information supplied by you will be treated in confidence by the Quinn Group and will not be disclosed to any third parties except where your consent has been received or where permitted by law. In order to provide you with products and services this information will be held in the data systems of the Quinn Group or our agents or subcontractors.</p> <p>The information you provide will be used to manage the administration of your policy, including underwriting and claims handling and for money laundering prevention purposes. We may undertake checks against publicly available information such as electoral roll, telephone directory, court judgements, bankruptcy or repossessions. Information may also be shared with other insurers either directly or via those acting for the insurer such as Loss Adjusters or Investigators.</p> <p>We may need to collect sensitive data (such as information about health or criminal convictions) relating to you and others named on the insurance policy. Please get consent from the other people named on your policy before sharing their sensitive information with us. By proceeding with this contract you will signify your explicit consent to such information being processed by us or our agents or other insurers for any of the purposes outlined above.</p> <p>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. Anonymised data may, however, be used by QUINN-healthcare, or disclosed to others, for research or statistical purposes.</p> <p>Access to non-medical information may be granted by QUINN-healthcare to others on a strictly confidential basis in the course, of, and for the purpose of, the efficient administration of QUINN-healthcare (for example: in connection with audit, systems development, managing or improving our services).</p> <p>If you have any enquiries about your data, please write to the Information Protection Manager, at QUINN-healthcare, Mill Island, Fermoy, Co Cork.</p>		
Members signature (a parent or guardian if patient is under 16)	Date			

5 Benefit payment details/payment method

Benefit payment - Hospital Accounts Direct Payment. We are pleased to assure you that under the direct payment to hospitals scheme QUINN-healthcare will settle most hospital accounts directly with your hospital. Simply complete the front of the claim form and the hospital will submit the claim for you. Under the 1988 Finance Act, QUINN-healthcare must pay benefit for doctor's fees direct to the doctors. We will also deduct withholding tax for the Revenue Commissioners.

Tick if you would like us to pay your hospital benefit entitlements to the hospital

6 New born baby details

Name of child

Please tick one: Male Female

You child's date of birth Day Month Year

Your child will be added to your cover free of charge until your renewal date. No waiting periods will apply if we have been notified within 13 weeks of the baby's date of birth. If you do not wish your child to be added, please tick here

7 Hospital details

Name and address of hospital

Name or number of ward

Please tick one: Private Semi-private Public ward

Admission date Day Month Year Discharge date Day Month Year

8 Consultant and medical details (to be completed by the consultant in overall charge of the patient)

Please give details by inserting a 'tick' in the appropriate box: Normal delivery Caesarean section Epidural injection

Please give details of any complications:

Please indicate other services, which were requested by you: Consultant Anaesthetist Pathology Radiology

Where a patient has a procedure with a length of stay guideline, which has become an outlier, please give the reason:

Did the baby require further treatment? If so, please supply details below:

Name and address of consultant who delivered the baby (BLOCK CAPITALS):

Signature of consultant

Consultant code

Date Day Month Year

9 Homebirths section

Was the baby born at home? Yes No Date of birth Day Month Year

Name and address of the attending Midwife/GP (if any):

Bord Altranais registration number of attending midwife:

Signature of midwife/GP: