

For In-Patient, Day-Case & Surgical Out-Patient treatment

Claim Form



USING THIS CLAIM FORM

This claim form has been designed to help you make a claim from us for in-patient, day-case or surgical out-patient treatment.

OUT-PATIENT AND MATERNITY CLAIMS

If you wish to make a claim for out-patient or maternity 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 answer all the questions below, complete the relevant sections, read and sign the declaration and consent section.

FURTHER INFORMATION

For benefits and claim queries, please contact us on 1890 700 890 or visit www.quinn-healthcare.com
Claims should be sent to: QUINN-healthcare, Mill Island, Fermoy, Co. Cork.

1 Member's details		
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 <input type="text"/>	Surname <input type="text"/>	Forenames <input type="text"/>
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 <input type="text"/>	
Correspondence address <input type="text"/>		
QUINN-healthcare scheme (Please insert your scheme name here): <input type="text"/>		
2 Patient details (if different from above)		
Title <input type="text"/>	Surname <input type="text"/>	Forenames <input type="text"/>
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 <input type="text"/>	
3 Symptom details		
When did you/the patient first notice symptoms? <input type="text"/>		
When did you/the patient consult with your family doctor for this condition? <input type="text"/>		
Have you/the patient claimed for this or related conditions before? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when? <input type="text"/>		
4 Doctors details		
Name of doctor first attended <input type="text"/>	Telephone <input type="text"/>	
Address <input type="text"/>		
5 Private patient	6 Benefit payment details/payment method	
Did you/the patient elect to be a private patient of the admitting consultant? Yes <input type="checkbox"/> No <input type="checkbox"/>	Benefit payment - Hospital Accounts Direct Payment. We are pleased to assure you that under the direct payment to hospitals scheme QUINN-healthcare will settle 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. <input type="checkbox"/> Tick if you would like us to pay your hospital benefit entitlements to the hospital.	
7 Accident Section (please complete in all cases involving injury)		
Description and date of accident/injury: Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>		
Are the expenses recoverable from another source? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, are you claiming these expenses through: Solicitor: Yes <input type="checkbox"/> No <input type="checkbox"/> or Personal Injuries Assessment Board: Yes <input type="checkbox"/> No <input type="checkbox"/>		
If either of the above are selected, please state the name, address and policy details: <input type="text"/>		
8 Hospital treatment section		
Name or number of ward <input type="text"/>		
Tick one: Private <input type="checkbox"/> Semi-private <input type="checkbox"/> Public ward <input type="checkbox"/> Day-case <input type="checkbox"/> Out-patient surgery dept <input type="checkbox"/>		
Was the patient in this bed for the entire length of stay? Yes <input type="checkbox"/> No <input type="checkbox"/> (If not, please give details of each bed occupied) <input type="text"/>		
Admission date Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/> Time <input type="text"/>		
Discharge date Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/> Time <input type="text"/>		
Where was the procedure carried out (please tick) <input type="checkbox"/> Consultant's Rooms <input type="checkbox"/> Hospital Theatre <input type="checkbox"/> A&E <input type="checkbox"/> Side Room <input type="checkbox"/> X-ray <input type="checkbox"/> Pathology Lab. <input type="checkbox"/> Minor Op. Theatre <input type="checkbox"/> Other, please specify <input type="text"/>		

9 MRI section (to be completed by consultant in overall charge of the patient)

Date of MRI	Date of onset of symptoms
Reason for referral	Name of referring consultant
MRI centre	
MRI procedure name(s) and code(s)	
Name and address of consultant in overall charge	Consultant code
Signature of consultant	Date: Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>

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

Nature of symptoms	
Date of on-set of symptoms Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	Date you first saw patient with symptoms Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>
Have there been previous episodes of this or related symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please give details	
Date of treatment: Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	Was the patient admitted as an emergency case? Yes <input type="checkbox"/> No <input type="checkbox"/>
a) Primary diagnosis	b) Secondary diagnosis
Full description and details of specialist investigations and/or treatment	
Procedure name(s) and Code(s)	
Where a patient has a procedure with a length of stay guideline, which has become an outlier, please give the reason	
Please give reason for hospital overnight admission for a procedure designated as a day-case procedure - where this is carried out as a sole procedure and is not part of continuing hospital treatment	
Was the patient transferred to any other hospital /establishment? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please give details	
Name and address of Hospital/Establishment	Overnight admission? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is this illness related to any addictive condition? (e.g. alcohol dependence, drug or substance abuse) Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please give details	
Is this illness related to any psychiatric condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please give details	
Please indicate other services, which were requested by you: <input type="checkbox"/> Consultant <input type="checkbox"/> Anaesthetist <input type="checkbox"/> Pathology <input type="checkbox"/> Radiology	
Name and address of consultant who treated the patient:	
Doctor code: B	
Signature of consultant in overall charge of patient	Date: Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>

11 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>I declare that QUINN-healthcare may contact my/the patients solicitor in order to ensure that any monies payable from a third party as a result of an accident or injury may be repayable to QUINN-healthcare.</p>	<p>DATA PROTECTION ACT 1988 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>				
<table border="1" style="width: 100%;"> <tr> <td style="width: 70%;">Members signature (a parent or guardian if patient is under 16)</td> <td style="width: 30%;">Date</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> </tr> </table>	Members signature (a parent or guardian if patient is under 16)	Date			
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