GloHealth
Hospital Claim Form
Direct Payment

To make life easier for you, we have a direct payment arrangement with a large number of hospitals and treatment centres, which means that we will pay the participating hospital or treatment centre directly. All you have to do is fill out parts 2-5 of this claim form at the end of your stay and we'll take care of the rest. If you have any questions please call us on **1890 744 744** or email us at **HappytoHelp@GloHealth.ie**.

PART 1: HOSPITAL DETAILS

This section needs to be completed by the hospital administration staff.

Please use an 'X' to mark the relevant boxes.

Hospital Name: _____ Hospital Code: _____

Admission Date: _____ Discharge Date: _____

Hospital stamp required for Government Levy

Admission to Hospital – please give details of the type of accommodation used during admission, including any types that are listed below.

Ward Type	Please 'X' Box(es)	Ward Name / Number	Room Name / Number	Bed Number	Number of Beds in Room	Number of Days
Private Room	☐					
Semi-Private Room	☐					
Public Ward	☐					
Day Ward	☐					
ICU / NICU	☐					
CCU	☐					

Treatment Setting — where the patient was not admitted to a ward please detail the treatment setting below.

☐ Theatre ☐ Sideroom ☐ A&E ☐ Radiology Dept ☐ Consultant / GP Rooms ☐ Minor Injury Unit

PART 2: POLICY DETAILS

This section needs to be completed by the policy holder or member.

Please use an 'X' to mark the relevant boxes

Your policy number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ (You will find this number on your GloHealth membership card)

Policy Holder's Name: _____ Patient's Name: _____

Policy Holder's Address: _____ Patient's Date of Birth: _____

_____ Contact Telephone No: _____

PART 3: HISTORY OF ILLNESS

This section needs to be completed by the policy holder or member.

Please use an 'X' to mark the relevant boxes.

Name and Address of the doctor that you first attended: _____ First consultation date: D D M M Y Y

_____

_____

_____

Have you had this or a similar illness before? Yes ☐ No ☐ If Yes, please give date and details: D D M M Y Y

Details: _____

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

Is your admission/treatment related to a Clinical Research Study? Yes ☐ No ☐

Was treatment as a result of an accident? Yes ☐ No ☐

PART 4: INJURY DETAILS

For completion in all cases involving injury (even if no third party is involved)

Please use an 'X' to mark the relevant boxes.

Injury Date: D D M M Y Y Place of injury: _____

Brief description of how the injury took place: _____

_____

Insurance company name: _____

PIAB contact name and reference number: _____

Do you plan to make a legal claim against a third party (parties)? Yes ☐ No ☐

Name and address of solicitor (where applicable): _____

_____ Phone Number: _____

PART 5: POLICY HOLDER/MEMBER AUTHORISATION

DATA PROTECTION

GloHealth Financial Services Ltd, trading as GloHealth is registered with the Office of the Data Protection Commissioner to act as a data controller in relation to the personal information held about you, and any other member on your policy under the Data Protection Acts, 1988 and 2003 as amended from time to time. The personal information you have provided will be used to administer, manage and advise on insurance products and for claims and the operation of anti-fraud policies on financial services provided by us, our insurance underwriters or other commercial partners in accordance with the Data Protection Acts. We shall share this information with our third party administrators, underwriters and any other commercial entity as required to provide the services. We will process this information and store it on our computer and manual record systems. To assist in preventing, detecting and/or protecting our customers and ourselves from theft and fraud, we may use your information to make searches of our or other companies' records, as well as those of other health insurers. If you give us false information or fail to disclose information and we suspect fraud, we will record this. We may in certain circumstances either directly or indirectly share your personal information with other insurers and participate in industry databases like that operated by the Irish Insurance Federation which allows for the sharing of information between insurers in order to check against non-disclosures. From time to time, we may record your telephone calls for training and verification purposes. If you would like a copy of the information we hold about you, please write to: GloHealth Financial Services Limited, PO Box 12218, Dublin 18. A fee of €6.35 should be enclosed with your request for your data. Should you discover any errors or omissions in the personal data held by us, or wish to change any of the uses of the data please contact us. GloHealth would like to use your details to keep you informed of other products or services offered by us or any third party with whom we may arrange such services. If you would rather not receive this information, and have not already informed us of this please let us know. Your details may also be used for these purposes after your policy has elapsed.

CONSENT

I declare that at the time I received medical treatment I was a party to a health insurance contract and under my GloHealth plan was entitled to this treatment. I declare that the treatment was recommended by my doctor, including any referral via accident and emergency, and that I was referred to the appropriate consultant for further treatment. I authorise the doctors/consultants/hospital who carried out this treatment to furnish GloHealth, or any duly appointed authorised agent acting on its behalf, with any information requested, including access to my hospital/medical records, where this is necessary in relation to any claim for treatment or services received by me or my named dependants. I authorise GloHealth to make direct payment to the extent specified by my GloHealth Plan to the doctors/consultants/hospital as appropriate for the services carried out and listed on this claim form.I confirm that I have read and understood the Data Protection Statement above. I verify the details of the accounts submitted on my behalf by the doctor/hospital/consultant as a true and accurate reflection of the treatment I received. I understand that the details of these amounts will be included in my GloHealth statement of payment and I will have the opportunity to contact GloHealth directly with any queries. I understand that any charges not covered under my GloHealth plan will remain my responsibility, or that of the named dependant who received the treatment, to settle directly with the doctors, consultant or hospital concerned. I undertake to GloHealth to include my hospital and medical expenses to the extent of the limits of my cover as part of my claim against a third party where GloHealth has discharged these expenses, and to inform my solicitor or Personal Injury Assessment Board to this effect when pursuing any claim. I declare that to the best of my knowledge, the information provided on this form is accurate, true and complete.

DECLARATION

I confirm that all the details, answers and information given in this form are true, accurate and complete. I confirm that I am giving my permission to you to use the information I have given on this form for the purposes set out in the Data Protection Section above.

Your Signature (You must sign here) _____ **Date:** D D M M Y Y

PART 6: MEDICAL HISTORY:

This section needs to be completed by the admitting consultant

Please use an 'X' to mark the relevant boxes.

Patient's Name: _____ Are you the admitting consultant? Yes ☐ No ☐

If No, please provide the name of the admitting consultant: _____

Who referred the patient to you? _____

Detail the nature of the symptoms: _____

_____

Duration of symptoms: D D M M Y Y **F.** Date patient first consulted you with symptoms/signs: D D M M Y Y

Was admission: Planned ☐ Emergency ☐ Has the patient had a previous admission for this condition? Yes ☐ No ☐

Has the patient a history of this condition? Yes ☐ No ☐ If Yes, please give date and details: D D M M Y Y

Details: _____

_____

Is the admission/treatment related to a Clinical Research Study? Yes ☐ No ☐

PART 7: MEDICAL INVESTIGATIONS

This section needs to be completed by the admitting consultant

Please use an 'X' to mark the relevant boxes.

Laboratory Investigations — Please give a summary of the key diagnostic tests that were performed:

_____

_____

If any laboratory tests were performed at another facility, please provide details of tests and facility:

_____

Radiology Investigations — please give a summary of the key diagnostic tests that were performed.

_____

_____

If any radiology investigations were performed at another facility, please provide details of the test and facility:

_____

Please give a description of the clinical indication for MRI/PET-CT Scan: _____ Date: D D M M Y Y

If the MRI/PET-CT was performed at another facility, please state the facility: _____

PART 8: DIAGNOSIS

This section needs to be completed by the admitting consultant

Please use an 'X' to mark the relevant boxes.

Please list primary, secondary and other diagnoses:

Primary Diagnosis: _____ Secondary/Other Diagnoses: _____

Are there any addictive elements involved with the illness (alcohol, drug or other substance abuse)? Yes ☐ No ☐

If yes, and this does not relate to the patient entire stay, please give the dates of treatment relating to addictive illness: Start: D D M M Y Y End: D D M M Y Y

PART 9: TREATMENT SECTION:

This section needs to be completed by the admitting consultant

Please use an 'X' to mark the relevant boxes.

Procedures Performed - Please complete this section detailing surgical, diagnostic and major medical illness procedures.

Procedure Code:	ICD Code:	Date of Service	Procedure Description:	Anaesthesia:
		D D M M Y Y		☐ General ☐ Monitored
		D D M M Y Y		☐ General ☐ Monitored
		D D M M Y Y		☐ General ☐ Monitored

If the patient was transferred to another facility for a procedure, please give details of the procedure and facility: _____

Please state reason for overnight/extended admission for procedures designated as One Night Only, Day Case or Side Room, or where Length of Stay exceeds outlier days for procedure with LOS guideline: _____

Medical Attendance: In non-surgical cases please list medical management including IV medications/IV fluids and/or treatments prescribed.

Description of treatment:

Procedure Code	ICD Code:	From:	To:
		D D M M Y Y	D D M M Y Y

Did you personally provide the services for which you have billed? ☐ Yes ☐ No

If No, please specify who provided the treatment: _____

PART 10: OTHER SERVICES:

This section needs to be completed by the admitting consultant

Please use an 'X' to mark the relevant boxes.

Did you request or any other consultant(s') services? ☐ Yes ☐ No

If Yes, please specify Consultant(s') name(s) in full: _____

PART 11: DISCHARGE STATUS:

This section needs to be completed by the admitting consultant

Please use an 'X' to mark the relevant boxes.

Home ☐ Still in this hospital ☐ Transfer to another hospital ☐ Convalescence ☐ Long-term care ☐ Deceased ☐

Is any further treatment anticipated? Yes ☐ No ☐ If Yes, please give details: _____

PART 12: CONSULTANT DECLARATION:

I hereby certify that the treatment I am claiming for was medically necessary and that the length of hospital stay was appropriate for the patient's medical condition as described on this form.

Consultant's Signature _____ GloHealth Consultant Code: ☐☐☐☐☐☐

Date: D D M M Y Y