Hospital Claim Form – Direct payment of medical charges

To make sure that you are not out of pocket, Aviva and most hospitals have a direct payment agreement that allows your claim to be settled directly between the hospital and Aviva. To facilitate this, Aviva may provide information to the hospital verifying your membership eligibility. All you need to do is complete Part 1 of the claim form and the hospital will submit the claim for you. If you have an out patient claim, please call 1850 717 717 at the end of your policy year.

Part 1

This part to be completed by the Patient and/or the Policyholder.

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

Daytime contact number or mobile of patient: Patient's date of birth (day/mth/yr): ☐☐/☐☐/☐☐

Was treatment received directly as a result of an accident? Yes ☐ No ☐ Did you elect to be a private patient of the consultant? Yes ☐ No ☐

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

History of illness section

Please complete this section in full.

When did you first suffer from these symptoms or illness? (day/mth/yr): ☐☐/☐☐/☐☐

When did you first visit your doctor with these symptoms? (day/mth/yr): ☐☐/☐☐/☐☐

Name and address of doctor first attended:

Telephone number of doctor first attended:

Have you ever made a claim for this or any other similar condition in the past with Aviva or any other health insurer? Yes ☐ No ☐

If yes, please supply details of where and when:

Personal injury claims

This section is for completion in the case of personal injury.

Date of occurrence of injury (day/mth/yr): ☐☐/☐☐/☐☐ Place of injury:

Brief description of how injury occurred:

Do you plan to pursue a claim against a third party? Yes ☐ No ☐

Third party claims

This section is for completion where you are making a claim against a third party (another person, company or public body, or where another person was responsible for your injury).

Name and address of person, company or public body responsible:

Name of insurance company: PIAB contact name:

Name of solicitor: Solicitor contact number:

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 Aviva plan. I declare 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 Aviva, 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 Aviva to the doctors/consultant/hospital as appropriate for the services set out on this claim form to the extent provided for under my Aviva 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 Aviva statement of payment and I will have the opportunity to contact Aviva directly with any queries. Charges not covered under the Aviva 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 Aviva discharging my hospital and medical expenses to the extent of cover limits, I undertake to Aviva 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 three** of this form.

Your signature: Date:

AVIVA

Part 2

This part to be completed in full by the admitting doctor/consultant/GP.

Patient's Full Name:

Are you the admitting consultant? Yes ☐ No ☐ If no, please state name of admitting consultant:

Please state the name of the person who referred the patient to you:

Was the admission: Emergency ☐ Planned ☐ Was this a re-admission for the same condition? Yes ☐ No ☐

Nature of symptoms:

a. Duration of symptoms: (day/mth/yr): ☐☐/☐☐/☐☐

b. Has the patient a history of these or any related symptoms? Yes ☐ No ☐

c. If yes, please give the details and dates of the treatments prior to this admission:

d. Is the admission/treatment related to a clinical research study? Yes ☐ No ☐

When did the patient first consult you with these symptoms? (day/mth/yr): ☐☐/☐☐/☐☐

Reason for admission (admitting diagnosis):

a. Primary:

b. Secondary:

Please supply full description and details of tests/treatment supplied covered by this claim:

Procedure Code 1: ☐☐☐☐☐ ICD Code: ☐☐☐☐ Date of Procedure: (day/mth/yr): ☐☐/☐☐/☐☐

Procedure Code 2: ☐☐☐☐☐ ICD Code: ☐☐☐☐ Date of Procedure: (day/mth/yr): ☐☐/☐☐/☐☐

Procedure Code 3: ☐☐☐☐☐ ICD Code: ☐☐☐☐ Date of Procedure: (day/mth/yr): ☐☐/☐☐/☐☐

Medical Attendance:
In non surgical cases please list medical treatment offered and description:

Procedure Code: ☐☐☐☐☐ ICD Code: ☐☐☐☐

From: (day/mth/yr): ☐☐/☐☐/☐☐ To: (day/mth/yr): ☐☐/☐☐/☐☐

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

If no, please supply details of who offered treatment:

Did you request attending consultant services? Yes ☐ No ☐

If yes, please provide details:

Was the patient transferred from the hospital during this visit for any other investigations? Yes ☐ No ☐

If yes, please supply the name of the hospital and nature of test/treatment performed:

Is any further treatment required? Yes ☐ No ☐

If yes, please supply outline of details:

Was patient transferred on discharge to a nursing/convalescence home by you? Yes ☐ No ☐

If yes, please supply details:

Declaration

I hereby declare 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.

Signature: (day/mth/yr): ☐☐/☐☐/☐☐

Aviva Doctor Code: ☐☐☐☐☐☐☐☐

Part 3 – Hospital details

This part to be completed in full by the hospital.

Name of hospital/place of treatment:

Date of admission (day/mth/yr): ☐☐/☐☐/☐☐ Date of discharge (day/mth/yr): ☐☐/☐☐/☐☐

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				
Day bed				
NICU / ICU				
CCU				

Hospital stamp:

Hospital code:

Please attach bill with relevant procedure code.

Data Protection

Aviva Health Insurance Ireland Limited ("we", "us" or "our"), as data controller, will keep the information you provide about yourself and about third parties confidential. We may use it to advise on, provide and administer insurance products and financial services provided by us or other Aviva companies and sometimes with our affiliates and/ or commercial partners, in order to comply with legal obligations imposed on us. We may share the information both inside and outside of the European Economic Area, in confidence, for these purposes with agents or service providers we have appointed, private investigators, regulatory organisations, other insurance and financial services companies (directly or via a central register), other Aviva Group companies, those to whom we outsource certain business operations and as required by law. 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 Aviva 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 also participate in industry databases such as those operated by the Irish Insurance Federation for the purpose of sharing of information among insurance companies as a check against non-disclosure.

From time to time, we may record your telephone calls for verification and training purposes.

If you would like a copy of the details we hold about you, please write to: Customer Services Manager, Aviva Health Insurance Ireland Limited, P.O. Box 764, Togher, Cork, Ireland. Please enclose the correct fee (€6.35). You also have the right to correct any errors in the information held about you, block certain uses or object to the processing of your personal data.

Important: Some of the questions on this form may ask for details about your health and convictions and the health and convictions of third parties material to this risk – please do not send us any genetic test results. This information is important for underwriting and claims purposes and will remain confidential. By signing the declaration overleaf, you are giving us permission to process these details for the above purposes, including checking with third parties or accessing State or other official records to verify whether the details you have given are accurate and complete. By signing the declaration overleaf, you are confirming that you have fully explained to each person who requires this insurance cover why we asked for this information and what we will use it for. You are also confirming each person has agreed to this.

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

We would like to use your details to provide you with information about other financial or insurance products, services and special offers either from us or other Aviva Group companies, or products, services and special offers which any member of the Aviva Group may arrange with a third party. Your details may also be used for this purpose (for up to 12 months) after your policy has ceased.

Please tick here ☐ if you do not wish to receive such information from us.

Your choice will not affect any of the services we provide to you, now or in the future.

Aviva Health Insurance Ireland Limited, P.O. Box 764, Togher, Cork
1850 717 717 www.aviva.ie/health

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