

# For Maternity Claims

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

# Claim Form

## IN ORDER TO MAKE A CLAIM

Please answer all the questions below, complete the relevant sections, read and sign the declaration and consent section and ensure the original invoices are attached.

## FURTHER INFORMATION

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. For benefits and claim queries contact us on 1890 700 890 or visit [www.quinn-healthcare.com](http://www.quinn-healthcare.com). Claims should be sent by the hospital to QUINN-healthcare, Eastgate Road, Eastgate Business Park, Little Island, Co. Cork

### Side 1 - To be completed in full by the patient

#### 1 Patient details

Membership no:

Title:  Surname:  Forenames:

Date of birth: Day  Month  Year  Telephone:

Address:

Did you elect to be a private patient of the Consultant? Yes  No

Name and address of the hospital you attended:

#### 2 Doctor's details

Name of doctor first attended:  Date: Day  Month  Year

Address:  Telephone:

#### 3 Newborn baby details

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 babies date of birth. If you **DO NOT** wish your child to be added, please tick here

First name of child	Surname of child	Date of birth	Gender
<input type="text"/>	<input type="text"/>	Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>

#### 4 Declaration and consent

##### Data Protection Statement

The information you provide will be used to manage the administration of your policy and is held in accordance with the **Data Protection Acts 1988 and 2003** (as amended). We may need to collect sensitive information (such as medical information) about you and others named on the insurance policy. By providing this information you will be agreeing to us or our agents or other insurers processing that information for the purpose outlined above. In the event that your treatment has involved another person, or if their details are likely to be documented in your Medical Notes/File, then their express consent should be acquired in advance of sharing sensitive data. 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. Information may also be shared with other insurers, either directly or through people acting for the insurer such as Investigators and where we are entitled to do so under the Data Protection Acts. You have a right to apply for a copy of the information held by us about you (for which a small charge, not exceeding €6.35, may apply) and you have a right to have any inaccuracies in your information corrected. Please send your request in writing to the Information Protection Manager, at QUINN-healthcare, Eastgate Road, Eastgate Business Park, Little Island, Co Cork.

##### Declaration and Consent

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 to the best of my knowledge and belief the information given on this form is true and complete. I authorise and request the hospital/specialist/consultant/physician/health provider concerned to furnish QUINN-healthcare or its duly authorised agents acting on its behalf (including, but not limited to, medical professionals whose services are retained by QUINN-healthcare for the purpose of assessing claims) with all necessary information as QUINN-healthcare or its authorised agents may seek in connection with any treatment or other services provided to me or my dependant(s) for the purpose of QUINN-healthcare considering this claim. This includes copies to my/the patient's hospital/medical records in relation to this claim regarding treatment or services received by me or my dependant(s). I confirm that I have read and understood the Data Protection Notice above. I confirm that I give explicit consent within the meaning of the Data Protection Acts 1988 & 2003 (as amended) to my/the patient's sensitive personal information (including my/the patient's hospital/medical records) being collected by QUINN-healthcare or its authorised agents. I confirm that I give explicit consent to this sensitive personal data being held, used and processed for the purpose of undertaking investigations into, and to adjudicate on, my/the patient's claim (including investigations into the length of my/the patient's hospital stay and the treatment I/the patient received whilst in hospital). I have examined and accept the accounts submitted in respect of this claim. Charges not eligible for benefit remain my responsibility to settle directly with the hospital and doctors concerned. I direct and authorise that all medical expenses (paid out by QUINN-healthcare) recovered from the third party responsible for my/the patient's injuries shall be refunded by my solicitor directly to QUINN-healthcare. I further direct my solicitor to deduct these amounts from my settlement cheque and reimburse QUINN-healthcare directly.

**X Patient signature**

(a parent or guardian if patient is under 16)

Date:

## 5 Hospital treatment section

Date of admission: Day   Month   Year

Time:

Date of discharge: Day   Month   Year

Time:

Room Type	Please mark with an 'X'	Ward/Room	Bed Number	Number of days in each bed
Private Room				
Semi-Private Room				
Public Ward				
Other - please specify				

## 6 Consultant and medical details (to be completed and signed by Consultant in overall charge of the patient. Claim will be returned if sections 6 & 7 are not completed in full)

Please give details by inserting a 'tick' in the appropriate box

Normal delivery  Caesarean section  Vacuum delivery  Forceps delivery

Please give medical indications if Caesarean section

Date of Delivery Day   Month   Year   Time of delivery

Anaesthesia General  Epidural  Both

Please give details of any complications

Please indicate other services which were requested by you Consultant  Pathology  Radiology  Other

If other please specify

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

Did you personally provide the service billed for Yes  No

Name of Consultant who delivered the baby (BLOCK CAPITALS)

## 7 Consultant declaration (to be completed and signed by the Consultant in overall charge of the patient)

I hereby declare that the treatment I am claiming for was medically necessary, personally provided by myself and the entire length of stay was due to the medical condition indicated on this form

Name of Consultant:

QUINN-healthcare Consultant code

**X** **Consultant signature**  
(You must sign here)

Date:

## 8 Homebirth section (to be completed by Midwife in overall charge of the patient)

Was the baby born at home Yes  No

Date of birth Day   Month   Year

Was the patient transferred to a hospital Yes  No  If Yes please give details

Equipment used for homebirth please specify

Number of consultations carried out

Cost per Consultation

Number of receipts included

Value of receipts

## 9 Midwife declaration

I hereby certify that I attended this patient for a home birth  
Name and address of attending Midwife:

Bord Altranais registration number:

**X** **Midwife/GP signature**  
(You must sign here)

Date:

**Claims should be sent to:**  
QUINN-healthcare, Eastgate Road,  
Eastgate Business Park,  
Little Island, Co. Cork

**QUINN**healthcare

Your insurance is provided by Quinn Insurance Limited (Under Administration), trading as Quinn Healthcare, which is regulated by the Central Bank of Ireland.