

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, please contact us on 1890 700 890 or visit www.quinn-healthcare.com. Claims should be sent by the hospital to: QUINN-healthcare, Eastgate Road, Eastgate Business Park, Little Island, Co.Cork.

To be completed in full by the patient

1 Patient details

Membership no.:

Title: Surname: Forenames:

Date of birth: Day Month Year

Address: Telephone:

Was treatment received directly as a result of an accident? Yes No If 'Yes' please complete section 5

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

2 Hospital details

Name of the hospital you attended: Date:

Address: Telephone:

3 Symptom details

When did you / the patient first notice symptoms? Day Month Year

When did you / the patient first consult with a doctor for this condition? Day Month Year

Have you / the patient claimed for this or related conditions before? Yes No

If Yes, when? Day Month Year

Please provide any other relevant information:

4 Doctor's details

Name of doctor first attended: Telephone:

Address: Date:



5 Accident Section

Date of accident / injury: Day Month Year

Description:
Place where accident/injury occurred?

How accident/injury occurred?

Was this accident / injury due to the fault of another party? Yes No

If Yes;
Name & Address of person, company or public body responsible?

Name of their insurance company?

Are you claiming these expenses through: Solicitor: Yes No or Personal Injuries Assessment Board: Yes No

Name & address of solicitor (where applicable):

6 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.

Patient signature (a parent or guardian if patient is under 16)

Date:



To be completed in full by Consultant and hospital

7 Hospital Treatment Section	HOSPITAL STAMP REQUIRED FOR GOVERNMENT LEVY
Date of admission: Day <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Month <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Time <input style="width: 40px;" type="text"/>	
Date of discharge: Day <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Month <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Time <input style="width: 40px;" type="text"/>	

Room type	Please mark with an 'X'	Ward/room	Bed number	Number of days in each bed
Private room				
Semi-Private room				
Public ward				
Day ward				
ICU / NICU / CCU				
Out-patient surgical				
Other - please specify				

Where was the procedure carried out (please tick):

<input type="checkbox"/> Consultants rooms / GP rooms	<input type="checkbox"/> Hospital theatre
<input type="checkbox"/> A&E	<input type="checkbox"/> Side room
<input type="checkbox"/> Pathology lab	<input type="checkbox"/> Minor op theatre
<input type="checkbox"/> Radiology department	<input type="checkbox"/> Other - Please specify:

To be completed by the Consultant in overall charge of the patient

8 Consultant and medical details (to be completed and signed by the Consultant in overall charge of the patient. Claim will be returned if sections 8 and 9 are not completed in full)

Nature of symptoms:	ICD Code: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
Date you first saw patient with symptoms: Day <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Month <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
Duration of symptoms prior to this: Days <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Weeks <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Months <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Years <input style="width: 20px;" type="text"/> <input style="width: 20px;" 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:	
By whom was the patient referred to you? Was the admission : Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Please specify medical indication which necessitated a hospital admission?	
Was inpatient admission requested by GP Consultant?	
a) Primary diagnosis:	ICD Code: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
b) Secondary diagnosis:	ICD Code: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
c) Other diagnosis:	ICD Code: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>

Please ensure that adequate and comprehensive information is provided in Nature of symptoms and Diagnosis fields. Failure to do so will result in the claim being returned without payment with a request for this information to be provided.

Full description and details of specialist investigations and / or treatment:

Procedure code	Date of service	Anaesthesia	Procedure description
<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="checkbox"/> General <input type="checkbox"/> Monitored	
<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="checkbox"/> General <input type="checkbox"/> Monitored	
<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="checkbox"/> General <input type="checkbox"/> Monitored	
<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="checkbox"/> General <input type="checkbox"/> Monitored	

Were IV medications / IV fluids administered to the patient? Yes No Duration of infusion:

Name of drug:

Dosage: Patient weight (KG):

Procedure code:

Date of service:

If prosthesis was used, please specify the name and number:

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

Please give the reason for hospital overnight admission where a procedure is a designated day-case procedure:

Discharge status: Home Convalescence Long-term care Deceased Transfer to another hospital

If transfer to another hospital, please specify name of hospital: Overnight admission: Yes No

Is this illness related to any addictive condition? (e.g. alcohol, drug or substance abuse) Yes No
If Yes, please give details:

Is this illness related to any psychiatric condition? Yes No
If Yes, please give details:

Please indicate other services requested by you: Consultant Anaesthetist Pathology Radiology Other - please specify:

To be completed by the Consultant in overall charge of the patient

9 In-patient MRI / CT section (to be completed and signed by the Consultant in overall charge of the patient. Claim will be returned if sections 8 and 9 are not completed in full)

Date of scan:	Name of centre:
Procedure(s) name & code(s):	
Description of anatomical site being examined:	
Name of Consultant in overall charge:	Consultant code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Consultant signature:	Date: Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>

10 Consultant Declaration

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: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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Consultant signature (You must sign here)	Date:
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