Out-patient Claim Form

Using this claim form

This claim form has been designed to help you make a claim from **laya healthcare** for out-patient expenses.

Guidelines to making your claim

- **Claim form to be signed by main member or policyholder**
- **Please note that out-patient receipts will not be returned following assessment.**
- Check that original out-patient receipts are enclosed (photocopies, cash register receipts, visa receipts etc. are not acceptable).
- Please ensure that all receipts include the name of the patient, the cost incurred and the date of the visit.
- The Revenue Commissioners will now accept your Statement of Claim (which we will send to you when your claim has been assessed) as evidence of medical expenses incurred.
- Claims should be made at renewal date and only for out-patient costs incurred within the previous membership year.
- If your scheme has an annual excess, this excess will be applied to your claim. The amount of the excess deducted will depend on your scheme.
- If you have not already provided your bank account details for your claims to be paid directly into your account, please complete Section 8 which requires the policyholder's signature.

Important note

For a full list of the out-patient benefits available on your scheme please visit the "How To Claim" section of our website, **www.laya healthcare.ie** or contact us on **1890 700 890** or Cork **021 202 2000.**

1 Member's details

Membership no: ☐☐☐☐☐☐☐☐☐☐

Title:	Surname:	Forenames:
Date of birth: Day ☐☐ Month ☐☐ Year ☐☐		Telephone:
Correspondence address:		
Email:		

2 Dependants' details for out-patient expenses

Name:	Relationship to main member:

3 MRI section (to be completed by Consultant in overall charge of the patient)

Date of MRI:

Reason for referral:

MRI centre:

MRI procedure name(s) and code(s):

Name of GP/Consultant who referred you for the MRI: Consultant code:

Date: Day ☐☐ Month ☐☐ Year ☐☐

4 Accidents section (please complete in all cases involving injury)

Description and date of accident/injury: Day ☐☐ Month ☐☐ Year ☐☐

Are the expenses recoverable from another source? Yes ☐ No ☐

If yes, are you claiming these expenses through: Solicitor: Yes ☐ No ☐ or Personal Injuries Assessment Board: Yes ☐ No ☐

If either of the above are selected, please state the name, address and policy details:

I declare that **laya healthcare** may contact my solicitor in order to ensure that any monies payable from a third party, as a result of an accident or an injury, are repayable to **laya healthcare** to offset against any claims we pay:

Signed (insured member if over 16) Signed (subscriber)

5 V.A.C Therapy

Date of hospital admittance relating to your V.A.C therapy: Day ☐☐ Month ☐☐ Year ☐☐

Please include your referral letter from your Consultant.

Hospital Name:

Consultant's Name:	Consultant Code:	Day ☐☐ Month ☐☐ Year ☐☐

6 Emergency dental section

Date and place of injury: Day ☐☐ Month ☐☐ Year ☐☐

Description of accident/injury:

To be completed by dentist providing treatment	Date:	Description of work carried out:	Cost:
Date treatment commenced:			
Treatment dates:			
Date treatment completed:			

Signature and stamp of dentist

7 Receipt details

Treatment type:	Number of receipts:	Total cost of receipts:	Treatment type:	Number of receipts:	Total cost of receipts:
1			5		
2			6		
3			7		
4			8		

8 Your payment details

To ensure prompt payment of your claim, we can arrange to make payment directly, where possible, into your bank account.

If you currently pay your subscriptions by Direct Debit and would like to have your claims paid, where possible, directly to this account please tick the box. ☐

If you have already provided your bank account details for your claims to be paid directly into your account, you do not need to resubmit this information.

Alternatively please complete the mandate with your bank account details. If you do not provide these details or if you provide us with incorrect bank details we will pay you by cheque.

Name(s) of account holder(s):

IBAN: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

BIC: ☐☐☐☐☐☐☐☐☐☐☐

Please write the full name and address of your bank or building society.

Policyholder's signature(s):

Date: Day ☐☐ Month ☐☐ Year ☐☐

I/we will inform **laya healthcare** if I/we wish to cancel the existing instruction for future claims payment.

9 Declaration and consent

I declare that the expenses detailed on this form were incurred by me and/or my dependants covered under my membership in respect of services received during the subscription year, on the recommendation of registered medical practitioners. I declare that, to the best of my knowledge, the foregoing statements are true in every respect.

Policyholder's signature
(a parent or guardian if patient is under 16)

Date:

Note: Payment and Explanation of Benefits will be issued to the policyholder.

Data Protection Act 1988 AND 2003

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**. However, anonymised data – that is, information which does not identify an individual – may be used by **laya healthcare**, or disclosed to others, for research or statistical purposes. Access to non-medical information may be granted by **laya healthcare** to others on a strictly confidential basis in the course of and for the purpose of the efficient administration of **laya healthcare** (for example in connection with audit, systems development, managing and improving our services). 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 **laya healthcare**, Eastgate Road, Eastgate Business Park, Little Island, Co Cork.

Claims should be sent to:
Laya healthcare, PO Box 12679, Dublin 15