Irish Life health

Overseas Pre-approval Form

Note: Disclaimer- Please note this form must be completed and **submitted 4 weeks in advance** of any planned travel for treatment abroad. This is to allow Irish Life Health time to consider your preapproval request. Please note submission of this form is not a guarantee of approval

PART 1 - Patient Details This part to be completed by the Patient

Patient's full name:	
Patient's membership number:*	
Patient's date of birth: (dd/mm/yy)	
Daytime contact number:	
Was treatment received directly as a result of an accident? (Please tick)	Yes No

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

History of Illness Section

When did you first suffer from these symptoms or illness? (dd/mm/yy)	
When did you first visit your doctor with these symptoms?(dd/mm/yy)	
Name of doctor first attended:	
Contact number of doctor first attended:	
Address of doctor first attended:	
Have you ever made a claim for this or any other similar condition in the past with Irish Life Health or any other health insurer?	Yes No
If yes, please supply details of where and when (including dates of treatments , treating physicians, and hospital details)	

Part 2: This part to be completed by the Patient and/or the Policy Holder.

Name of overseas Hospital/ Place of Treatment:	
Full address of overseas Hospital/ Place of Treatment:	
Telephone number of overseas Hospital/Place of Treatment:	
Email of overseas Hospital/ Place of Treatment:	
Contact name at overseas Hospital/ Place of Treatment:	
Date of travel to Overseas facility: (dd/mm/yy)	
Planned date of admission to facility: (dd/mm/yy)	
Planned date of discharge from facility: (dd/mm/yy)	
Expected hospital costs:	€
Expected Consultant cost:	€

Declaration

I declare that at the time I applied for overseas treatment I was a party to a health insurance contract and was entitled to treatment under my Irish Life Health plan. I declare that my doctor recommended the treatment (including accident and emergency referral) 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 understand that I must have been referred for the surgical procedure/treatment abroad by a participating consultant in Ireland or through the International Second Opinion Service benefit, where applicable. I authorise the doctors, consultant or hospital to furnish Irish Life Health, or any authorised agent it may appoint to act on its behalf, with any information requested. This includes access to my hospital/medical records, where necessary, in relation to treatment or services received by me or my named dependants in respect of this claim. I understand that only medical information relating to my claim will be requested by Irish Life Health. I understand that charges incurred for overseas treatment 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 have read the terms and conditions in my member handbook and I understand that costings are allowed in line the the costs and medical facilities here in Ireland, and as per the cover on my policy.** In consideration of Irish Life Health discharging my hospital and medical expenses to the extent of cover limits, I undertake to Irish Life Health 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. I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I understand this pre-approval if granted is valid for 6 months from the date of approval .Should the 6 months lapse while I awaiting treatment I understand that I must resubmit a new pre-a pproval for consideration. I also understand the surgical procedure must be performed or treatment must commence within 31 days from when I leave Ireland. I understand that the information will be used to process the claim as outlined above and for the purposes as set out in the ILH privacy notice which can be found at http://www.irishlifehealth.ie/privacy-and-legal/privacy-statement/

Print name in block capitals:	
Member Signature:	
Date: (dd/mm/yy)	

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Part 3: This part to be completed in full by the Referring Doctor/Consultant.

Note: Referring Doctor/Consultant must hold a current full registration with the Irish Medical Council.

Consultant and medical section

Patient's Full Name:	
Name of the person who referred the patient to you:	
Nature of symptoms:	
When did the patient first consult you with these symptoms?	
Is this treatment related to a clinical research study?	Yes No
History of treatment to date:	
Primary diagnosis:	
Secondary diagnosis:	

Procedure code 1:		ICD code:		Date of procedure: (dd/mm/yy)
Procedure code 2:		ICD code:		Date of procedure: (dd/mm/yy)
Procedure code 3:		ICD code:		Date of procedure: (dd/mm/yy)

Please supply a full description and details of the surgical treatment to be performed:

What is your rational for requesting overseas treatment : (Please tick 1)

(i)   Your preferred choice

(ii)   Procedure not available in Ireland

(iii) Available in Ireland, but wait times are too long

How will the patient be transported to and from the hospital during this visit?	
What is the expected outcome of the proposed surgical treatment?	
What is the expected length of stay in hospital?	
Is any further treatment required?	Yes No
If yes, please supply outline of details:	
Will the patient be discharged to a place of convalescence?	Yes No
If yes, please supply outline of details:	

Declaration

I hereby declare that the proposed treatment described above is medically necessary and appropriate for the patient's medical condition, as described on this form:

Print name in block capitals:	
Consultant signature:	
IMC registration number:	
Date: (dd/mm/yy)	