Irish Life health

Maternity Claim Form
Direct Payment of Medical Charges

To make sure that you are not out of pocket, Irish Life Health and most hospitals have a direct payment agreement that allows your claim to be settled directly between the hospital and Irish Life Health. To facilitate this, Irish Life Health may provide information to the hospital verifying your membership eligibility. All you need to do is complete Part 1 of the claim form, sign at the bottom of page 2 and the hospital will submit the claim for you. Please do not submit bills and claims directly to Irish Life Health, unless the hospital does not have direct payment. We will send you a statement of the benefits paid on your behalf.

Failure to complete the claim form correctly may result in the return of the claim in its entirety.

On some of our plans, your child can be added to your cover, free of charge, until your next renewal date. Please contact us on 01 5625100 to arrange this cover.

Part 1 (To be completed by Patient and/or the Policy Holder)

Patient's full name:											
Patient's membership number:*											
Patient's date of birth: (dd/mm/yy)											
Daytime contact number:											
Patient's relationship to policyholder:											
Did you elect to be a private patient of the consultant? (Please tick)								Yes	◯	No	◯

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

Home Births (If the birth was a home birth, please complete this section)

Date of delivery: (dd/mm/yy)											
Name of the attending midwife/GP:											
Address of the attending midwife/GP:											
Midwife's Bord Altranais registration number:											

Please attach relevant receipts.

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Declaration

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 Irish Life Health 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 or hospital to furnish Irish Life Health, 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 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 authorise the direct payment by Irish Life Health to the doctors/consultant/hospital as appropriate for the services set out on this claim form to the extent provided for under my Irish Life Health 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 Irish Life Health statement of payment and I will have the opportunity to contact Irish Life Health directly with any queries. Charges not covered under the Irish Life Health 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 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 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

https://www.irishlife.ie/health-insurance/privacy-and-legal/data-privacy-notice/

Signature (member)	
Date: (dd/mm/yy)	

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Part 2 (To be completed by Maternity Consultant)

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

Patient's full name:	
Procedure code:	
Vaginal Delivery:	Yes ◯ No ◯
If Yes, please specify if:	
Did any complications exist throughout the pregnancy? ◯	Hypertension ◯ High Risk Pregnancy ◯ None ◯ Other ◯
Please specify detail:	
Date of delivery: (dd/mm/yy)	
Please confirm if you personally attended the delivery:	Yes ◯ No ◯
Did the patient require ICU services?	Yes ◯ No ◯
If yes, please confirm days spent on mechanical ventilation?	
Type of anaesthesia administered:	General ◯ Monitored ◯ Regional ◯ Epidural ◯ No Anaesthesia ◯
Please confirm if delivery resulted in:	Single birth ◯ Twin Birth ◯ Multiple Birth ◯
Birth weight of new born:	

Consultant signature:	
Date: (dd/mm/yy)	
Irish Life Health Doctor Code:	

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Part 3 - Hospital Details: (This part to be completed in full by the Hospital)

Name of hospital/place of treatment:	
Date of admission: (dd/mm/yy)	
Date of discharge: (dd/mm/yy)	
Time of admission: (hh.mm)	
Time of discharge: (hh.mm)	

Room Type	Please tick	Ward/Room Name/Number	Bed number	Number of days in each bed
Private room	◯			
Semi-private room	◯			
Public room	◯			
NICU/ICU/HDU/CCU	◯			

Total number of days the patient did not occupy the above bed(s) during this admission:	

Hospital code:	
Hospital stamp:	

Please attach bill with relevant procedure code.