Gender Affirmation Procedures Pre-authorisation Form

Application for gender affirmation surgical treatment under the Gender Affirmation Benefit or the Gender Affirmation Support Benefit.

Note: All surgical treatment overseas must be pre-approved in advance of travel.

Part 1 and Part 2 of this form (including the consent below) must be completed by the Patient orPolicyholder (where the patient is under 18 years of age) who is applying for surgical treatment. Part 3 must be completed by the referring Consultant in Ireland.

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

Patient's name as it appears on the policy:	
Patient's preferred name:	
Patient's membership number:*	
Patient's date of birth: (dd/mm/yy)	

*This can be found on your digital membership card and on your policy documents

History of condition

When were you first diagnosed with gender dysphoria? (dd/mm/yy)	
When did you first visit your doctor regarding gender dysphoria? (dd/mm/yy)	
GP name:	
Endocrinologist name (if applicable):	
Psychiatrist name:	
Surgeon name:	
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:	

Part 2: This part to be completed by the Patient and/or the Policyholder (where the patient is under 18 years of age).

Name of Hospital/Place of Treatment:	
Full address of Hospital/Place of Treatment:	
Actual or expected date of admission: (dd/mm/yy)	
Actual or expected date of discharge: (dd/mm/yy)	

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 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. 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/

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

Irish Life health

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

Notes: Referring Consultant must hold a current full registration with the Irish Medical Council
A mental health assessment and medical history, including confirmation of hormone therapy and Real Life Experience should accompany this pre-authorisation form.

Consultant and medical section

Patient's Full Name:					
Patient's preferred name:					
Description of presenting condition:					
C Does the patient have real life experience living as their chosen gender?			Yes ◯	No ◯	
Details and Dates of Experience (including details of any change of name and/or Gender Recognition Certificate acquired)					
When did patient first consult you with the condition? (dd/mm/yy)					
Any other treatment or surgery in addition to the above:					

Primary procedure to be performed:	
Secondary procedure to be performed:	

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 full description and details of surgical treatment to be performed:

What is the expected length of stay in hospital?				
Is any further treatment required?	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:

Consultant Name (Block capitals):					
Signature:					
Date: (dd/mm/yy)					