

Claim Form for Fertility Treatment

Claim Form required to support each service incurred



Section 1: Policy Details - for completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age)

1.1 Quote Policy No. Here: from your Vhi membership card.

1.2 Patient's Name: _____ 1.4 Policy Holder's Name: _____

1.3 Patient's Address: _____ 1.5 Patient's Date of Birth:

1.6 Contact Telephone No.: _____

1.7 Email Address: _____

Please check that you have entered your Policy Number

Please note that the address you provide is purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Services Helpline at (056) 444 4444.

Section 2: Details of Treatment in Facility - for completion by the Treatment Centre

Please complete the following section for benefit claimed.

2.1 Facility Code: 2.2 Date of Service:

2.3 Facility Name and Location: Beacon Care Fertility - Dublin

As benefits may vary according to your plan please refer to your Vhi Rules - Terms and Conditions of Membership and your Table of Benefits to understand the benefits you are entitled to claim under your current plan.

Section 3: Claim Details - for completion by the Consultant (Please place 'X' in required boxes)

3.1 Benefit claimed: IUI IVF ICSI Fertility Counselling Sperm Freezing Egg Freezing

Initial Consultation Fertility Test PGT FET

3.2 International Classification of Diagnosis-10

General information about your presentation was recorded by your clinician using standard anonymous codes, called the International Classification of Diagnoses-10 (ICD-10).

3.3 Primary Diagnosis (Underlying Cause): _____

3.4 Secondary Diagnosis (Underlying Cause): _____





Section 4: Consultant Declaration

I hereby certify that the treatment specified was necessitated by the condition described by me above, and was justified by the patient's medical condition.

| | | |
|---|-------|--|
| X Consultant's Signature (You must sign here) | _____ | Consultant Code: <input type="text" value="1"/> <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="9"/> <input type="text" value="6"/> |
| | | Date: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="2"/> <input type="text" value="4"/> |

Section 5: Patient or Parent/Legal Guardian (if patient is under 18 years of age) Authorisation

Data Protection Statement

In order to adjudicate on your claim, Vhi will process the personal data that you have provided on this form, together with any personal data that you have authorised third parties to provide to us. Certain processing of your personal data is required in order for us to adjudicate on your claim and for us to be able to operate the business of providing health insurance policies, whereas some processing of your personal data is optional. You can indicate your consent to the optional processing of your personal data below.

Vhi Insurance DAC of Vhi House, Lower Abbey Street, Dublin 1 is the company that controls and is responsible for processing the personal data in relation to your claim. It will process your personal data in accordance with the Vhi Data Protection Statement which has previously been provided to you. If you would like another copy of the Vhi Data Protection Statement it is available at Vhi.ie, or you can request a copy by calling us on **(056) 444 4444**.

Obtaining Copies of Your Medical Information

In order to process and to establish the eligibility and appropriateness of your claim we will contact the facility and your treating practitioners (including, where relevant your GP) on your behalf to request a copy of all necessary information including, if requested, copies of the facility/medical records relating to the treatment and/or services received by you as part of this claim.

Optional Consents

We would like to process your personal data (or if you are a parent/legal guardian acting on behalf of a dependant under 18 years, the personal data you provide on their behalf) for the purposes set out below. This is entirely optional, and **will not affect the processing of the claim**.

- Advisory** I consent to Vhi processing personal data in relation to this claim, and past claims, including details of any medical conditions and treatment, in order to undertake analysis and profiling of medical and health insurance needs. I understand Vhi will use this to identify individual needs, which will help Vhi to tailor communications and advice to me in connection with the renewal of my policy either by post, phone, email or SMS (based on my chosen method of communication).
- Surveys** I consent to Vhi processing personal data in relation to this claim, and past claims, including details of any medical treatments, to allow Vhi to invite me to participate in surveys. If I am eligible to participate, I consent to Vhi contacting me to ask me to participate by post, phone, email or SMS (based on my chosen method of communication).
- Direct marketing** I consent to Vhi processing my personal data in relation to this claim, and past claims, including details of any medical conditions and treatments, to offer me personalised products and services which are relevant to my needs by post, phone, email or SMS (based on my chosen method of communication).

Withdrawal of Consent

Please note that where you have given consent to Vhi processing your personal data you may also withdraw that consent at any time. If you would like to withdraw your consent, or if you have any other queries, or if you wish to change your chosen method of communication, please contact us using any of the following channels:

- **Post:** Vhi Healthcare, IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.
- **E-Mail:** info@vhi.ie
- **Phone:** (056) 444 4444
- **Online:** MyVhi or the Vhi Health Assistant App

Authorisation – YOU MUST SIGN HERE

I declare that the information completed above at the time of signing this declaration is true in every respect. I authorise Vhi to pay the appropriate benefits, for services provided, to the treatment facility and medical practitioners concerned. I understand that the details of these amounts will be included in my Vhi statement of payment and I will contact Vhi directly with any queries. Charges which are not eligible for benefit will remain my responsibility to settle directly with the treatment facility/medical practitioner concerned.

| | | |
|---|-------|---|
| X Signature of Patient or Parent/Legal Guardian (on behalf of a dependant under 18 years at the time of treatment)* | _____ | Date: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="2"/> <input type="text" value="4"/> |
| | | |

*For claims in relation to a dependant under 18 years at the time of treatment, please note that all correspondence and relevant payments will be made to the Policyholder. If the dependant turns 18 while the claim is in progress, Vhi will continue to correspond with the Policyholder until the claim is concluded.

Vhi Insurance DAC trading as Vhi Insurance is regulated by the Central Bank of Ireland.

Please check that you have entered your Policy Number in Section 1.

Please note that the address you provide is purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Services Helpline at **(056) 444 4444**.



Claim Form Submission Address: Vhi, PO Box 10143, Dublin 18.

Dublin: Vhi House, Lower Abbey Street, Dublin 1.

Fax: (01) 873 4004

Cork: Vhi House, 70 South Mall, Cork.

Fax: (021) 427 7901

Kilkenny: IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.

Fax: (056) 776 1741



Office opening hours: 10am-4pm Monday to Friday.

Tel: (056) 444 4444.

Lines open 8am-7pm Monday to Friday and 9am-3pm Saturday.

Contact: Vhi.ie

Vhi.ie/contact

