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# Hospital Claim Form

OFFICE USE

**PART 1**

***Must be completed in full and signed personally by the patient or guardian.***

**Patient Name:** ______________________________

**Membership No.:** ____________________ **D.O.B.:** ____________________

## COMPLETE EITHER SECTION (a) or (b) BELOW

(a) If your hospital admission was pre-arranged by a Consultant on your behalf please provide;

Name of your Consultant: ______________________________

Date of your last Consultation: ______________________________

(b) If your admission to this hospital was through the Accident and Emergency Department, we require confirmation that you **choose and opted** to be treated as a private fee paying patient.

Did you choose to be treated as a private fee paying patient - **YES** ☐ **NO** ☐

If **YES,** give the date you made the request: ______________________________

Name of the Consultant you requested to treat you as a private fee paying patient:

***CONSULTANTS NAME:*** ______________________________

**DID THIS HOSPITAL ADMISSION ARISE FOLLOWING A;**

**Road Traffic Accident, Injury on Duty or a Sporting Injury?**

**Please tick - YES** ☐ **NO** ☐

***(THIS QUESTION MUST BE ANSWERED BEFORE CLAIM CAN BE ASSESSED)***

***I confirm that I personally completed and signed this form and I authorise the release of all my medical records if requested by the Society to evaluate and assess this claim.***

Signed by Patient or Guardian: ____________________ Date: ____________________

**PART 2**

***To be completed and CERTIFIED by a Hospital Representative for all Inpatient and Day Case Claims***

**Did this patient at admission choose treatment as a Private Patient - YES** ☐ **NO** ☐

If YES, please complete the following section; **Inpatient** ☐ **Daycase** ☐

Period of Hospitalisation - From ________________ to ________________ number of days_______

## ACCOMMODATION DURING HOSPITALISATION:

**PUBLIC WARD** From____________________ To ____________________ No. of Days ______

**SEMI-PRIVATE ROOM** From____________________ To ____________________ No. of Days ______

**PRIVATE ROOM** From____________________ To ____________________ No. of Days ______
**(Semi-Private Rate only payable by Society)**

**Ward Name:**____________________________________________ **Designated Bed No.** ______________

**Ward Name:**____________________________________________ **Designated Bed No.** ______________

Was this patient transferred form another facility/hospital for treatment or to another facility/hospital during or following treatment?
If so, please give details: ______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

***I <u>certify</u> that on the dates invoiced, this patient was at all time accommodated in a <u>DESIGNATED SEMI-PRIVATE BED or DAYCASE BED</u> within this hospital in the designated bed number outlined above and that he/she requested/choose at admission to be treated as a private fee paying patient.***

Signed:____________________________________________ Position: ______________________