Plaza 255, Blanchardstown Corporate Park 2,
Ballycoolin Rd., Dublin 15.
Tel: 01 899 1604. Fax: 01 899 1707.
E-mail: customerservice@medicalaid.ie
Website: www.medicalaid.ie

Consultant Claim Form

OFFICE USE

To be completed and signed personally by the patient or guardian.

Patient Name: ____________________

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

NOTE: THE SOCIETY PROVIDES FULL COVER AT THE PARTICIPATING CONSULTANT RATE APPLYING CURRENTLY. YOU WILL HAVE A BALANCE BILL IF YOUR CONSULTANT IS NON-PARTICIPATING.

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 to this Consultant.

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

Signed by Patient or Guardian: ____________________ Date: ____________________

TO BE COMPLETED BY ALL ATTENDING CONSULTANTS.

Are you the admitting Consultant? **YES** ☐ **or** **NO** ☐

Are you a treating Consultant? **YES** ☐ **or** **NO** ☐

Provide **Full Details/Symptoms/Duration of the Medical Condition** necessitating this treatment;

Date first consulted on this issue ____/____/_____ was the admission Planned ☐ Emergency ☐

Please supply details of the procedure codes delivered during treatment;

Procedure Codes 1______________ 2________________ 3______________ Date ____/____/_____

Was any Procedure Code delivered on a different date Code ___________ Date____/_____/____

Scans and or Tests Ordered - Details:____

____

Was any other Consultant involved in the treatment: Details ____

____

Do you anticipate any further treatment: Details ____

____

DISCHARGING CONSULTANT: I confirm that this patient completed their acute medical treatment and was fit for discharge from this hospital on - Date ____ /_____/_____.

ALL ADMITTING/TREATING and DISCHARGING CONSULTANTS: I confirm that I am a Consultant with an employment contract which entitles me to claim fees for the treatment of Private Patients and the treatment provided was medically necessary and the length of hospital stay was appropriate for the medical condition outlined above and the details of their claim are correct and accurate.

Signature:____ Date: _____________________________

(Must be signed by Consultant)

Consultant GMA No:______________________________________ PPS Number:______________________