Out-patient Claim Form

laya healthcare
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Using this claim form

Claims should be sent to: **Laya healthcare**, PO Box 12679, Dublin 15.

Guidelines to making your claim for out-patient expenses

- The Revenue Commissioners will now accept your Statement of Claim (which we will send to you when your claim has been assessed) as evidence of medical expenses incurred
- Claims must be submitted within 12 months of the treatment date on your receipt
- Claims should be made at renewal date
- If your scheme has an annual excess, this excess will be applied to your claim. The amount of the excess deducted will depend on your scheme
- If you have not already provided your bank account details for your claims to be paid directly into your account, please complete Section 2 which requires the policyholder's signature.

Important note

For a full list of the out-patient benefits available on your scheme please log in to the "Member Area" in our website, **www.layahealthcare.ie** or contact us on **1890 700 890** or Cork **021 202 2000.**

1 Member's details

Membership no: ☐☐☐☐☐☐☐☐☐☐

Title:	Surname:	Forenames:
Date of birth: Day ☐☐ Month ☐☐ Year ☐☐		Phone (mobile preferred):
Correspondence address:		
Email:		

2 Your claims payment details

To ensure prompt payment of your claim, we can arrange to make payment directly, where possible, into your bank account. If you currently pay your subscriptions by Direct Debit and would like to have your claims paid, where possible, directly to this account please tick the box. ☐

If you have already provided your bank account details for your claims to be paid directly into your account, you do not need to resubmit this information. Alternatively please complete the mandate with your bank account details. If you do not provide these details or if you provide us with incorrect bank details we will pay you by cheque.

Name(s) of account holder(s):

IBAN: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

BIC: ☐☐☐☐☐☐☐☐☐☐☐

Please write the full name and address of your bank or building society.

Policyholder's signature(s):

Date: Day ☐☐ Month ☐☐ Year ☐☐

I/we will inform **laya healthcare** if I/we wish to cancel the existing instruction for future claims payment.

3 Declaration and consent

I declare that the expenses detailed on this form were incurred by me and/or my dependants covered under my membership in respect of services received during the subscription year, on the recommendation of registered medical practitioners. I declare that, to the best of my knowledge, the foregoing statements are true in every respect.

X **Policyholder's signature**
(a parent or guardian if patient is under 16)

Date:

Note: Payment and Explanation of Benefits will be issued to the policyholder.

Data Privacy Statement

The information you provide will be used to manage the administration of your policy and is held in accordance with data protection law .We may need to collect sensitive information about you and others named on the insurance policy, which is set out in our Privacy Policy (see below). By providing this information you will be agreeing to us or our agents or other insurers processing that information for the purpose outlined above. You can only share a dependent's information with us, with their full permission (unless agreed otherwise with **laya healthcare**). Medical information will be kept confidential and may be disclosed, on a strictly confidential basis to those involved with your treatment or care or their health professional agents. Information may also be shared with other insurers, either directly or through people acting for the insurer such as Investigators and where we are entitled to do so under the Data Protection Acts. However, anonymised data – that is, information which does not identify an individual – may be used by **laya healthcare**, or disclosed to others, for research or statistical purposes. Access to non-medical information may be granted by **laya healthcare** to others on a strictly confidential basis in the course of and for the purpose of the efficient administration of **laya healthcare** (for example in connection with audit, systems development, managing and improving our services). You have a right to apply for a copy of the information held by us about you (for which a small charge, not exceeding €6.35, may apply) and you have a right to have any inaccuracies in your information corrected. More details about your rights and how we collect, use and disclose your Personal Information can be found in our full Privacy Policy at https://www.layahealthcare.ie/privacypolicy/ or you may request a copy by writing to Ian Brennan, Privacy Lead, **Laya Healthcare**, Eastgate Road, Eastgate Business Park, Little Island, Co Cork, T45 E181 or by emailing info@layahealthcare.ie

4 Receipt details

Treatment type:	Number of receipts:	Total cost of receipts:	Treatment type:	Number of receipts:	Total cost of receipts:
1			6		
2			7		
3			8		
4			9		
5			10		

5 Accidents section (please complete in all cases involving injury)

Description and date of accident/injury: Day ☐☐ Month ☐☐ Year ☐☐

Are the expenses recoverable from another source? Yes ☐ No ☐

If yes, are you claiming these expenses through: Solicitor: Yes ☐ No ☐ or Personal Injuries Assessment Board: Yes ☐ No ☐

If either of the above are selected, please state the name, address and policy details:

I declare that **laya healthcare** may contact my solicitor in order to ensure that any monies payable from a third party, as a result of an accident or an injury, are repayable to **laya healthcare** to offset against any claims we pay:

Signed (insured member if over 16) Signed (subscriber)

6 Emergency dental section

Date and place of injury: Day ☐☐ Month ☐☐ Year ☐☐

Description of accident/injury:

To be completed by dentist providing treatment	Date:	Description of work carried out:	Cost:
Date treatment commenced:			
Treatment dates:			
Date treatment completed:			

Signature and stamp of dentist

Checklist:

Please ensure the following are completed so we can assess your claim

Please Tick ✓

- Did the main policyholder* sign the claim form? ☐
- Did you input your bank account details so payment can be made quickly, directly into your account? ☐
- Did you supply the original receipts? ☐
- Did you make a copy of your receipts for your own records, as it is the company policy of **laya healthcare** not to return the original receipts? ☐
- Do all your receipts include the name of the patient, the name of the GP, consultant, therapist etc, the cost incurred and the date of the visit? ☐

***The policyholder is the first name listed on the policy. All other members are classed as dependants.**

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