St. Pauls Garda Medical Aid Society

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

Hospital Claim Form

(OFFICE USE ONLY)

If you have a query, please contact the office above for assistance.

MAKING A CLAIM

IN ORDER TO CREATE A VALID CLAIM, PLEASE ENSURE ALL QUESTIONS LISTED ARE FULLY ANSWERED, SIGNATURES INSERTED AS REQUIRED AND ALL INVOICES (ORIGINAL COPIES ONLY) ARE ATTACHED TO AVOID THE CLAIM BEING RETURNED FOR COMPLETION

Page 1 to be completed in full by the Member or Guardian
Page 2 to be completed in full by the Hospital
Pages 3 and 4 to be completed in full by the Attending Consultant/s

SECTION 1 MEMBERSHIP DETAILS (Member/Guardian must complete and sign this form)

1.1 Membership Number: _____ (Staff Number as Policy No)

1.2 Patient Name: _____

1.3 Address _____

_____

1.4 Date of Birth: _____ 1.5 Telephone No: _____

SECTION 2 INJURY SECTION (Must be completed in all instances)

Did this hospital admission arise as a result of any of the following:

2.1	Road Traffic Accident	Yes ☐	No ☐
2.2	Injury on Duty/Occupational Injury	Yes ☐	No ☐
2.3	Third Party Injury	Yes ☐	No ☐
2.4	Sporting Injury	Yes ☐	No ☐
	Are you pursuing a claim for costs against another party?	Yes ☐	No ☐

The above questions must be answered before the claim can be assessed.
If the answer is yes or you are unsure, a legal undertaking/indemnity form must be completed and signed before the claims will be cleared for payment. These forms are available from the office above.

SECTION 3 REQUEST FOR PRIVATE CARE (to be completed by Patient/Guardian)

3.1 Did you elect to be treated as a private patient by your Consultant? Yes ☐ No ☐

3.2 Please advise date that you opted to be treated as private patient by your Consultant Date: _____

3.3 I confirm that I signed and dated this form on admission or during my hospital stay Yes ☐ No ☐

In electing for private care, I authorise the consultant/hospital concerned to supply all necessary information to my insurer including, if requested, copies of my hospital/medical records. I also authorise my insurer to pay the appropriate benefits for services provided to the hospital and consultants concerned. Charges which are not eligible for benefit will remain my responsibility to settle directly with the hospital or consultant.

I have signed the PRIVATE INSURANCE PATIENT FORM provided to me by the hospital and understood its contents
(Applies to Public Hospitals only)

(OFFICE USE ONLY)

I declare that the information completed above is true in every respect

Member or Guardian Signature _____ Date _____