PUBLIC HOSPITAL CLAIM FORM

For office use only ____________

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 should be completed by the Member or Guardian

Page 2 should be completed by the Hospital

Page 3 & 4 should be completed by the Attending Consultant/s

SECTION 1 Membership Details (Member/Guardian must complete and sign)

1.1 Staff Number: ____________

(To be used as MPF Policy No)

1.2 Patient Name: ____________

1.3 Address: ____________

____

____

1.4 Date of Birth: ____________ 1.5 Telephone No: ____________

SECTION 2 Injury Section (For completion if applicable)

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

2.1 Road Traffic Accident	Yes ☐	No ☐		2.3 Third Party Injury	Yes ☐	No ☐
2.2 Occupational Injury	Yes ☐	No ☐		2.4 Sporting Injury	Yes ☐	No ☐

Are you pursuing a claim for cost against another party? ____________

This question must be answered before the claim can be assessed. If the answer is yes or unsure, an indemnity form must be completed and signed before the claim will be cleared for payment. This form is available from the MPF office.

SECTION 3 Request for Private Care (to be completed by Patient/Guardian)

3.1 Did you elect to be treated as a private patient? ____________

3.2 Please advise date that you opted to be treated as a private patient Date: ____________

3.3 If dated after admission/discharge date, please provide the reason: ____________

In electing for private care, I authorise the consultant/hospital concerned to supply all necessary information to MPF including, if requested, copies of my hospital/medical records & inclusive of medical reports. I also authorise MPF 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

ESB Medical Provident Fund requires the above information to enable us to apply the benefits as per level of cover.
The data controller is ESB Medical Provident Fund.
Please refer to our Privacy Notice, available at www.esbmpf.ie or we will provide a copy on request.

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

Name: (Block Capitals Please) ____________ Date: ____________

Member signature: ____________

OFFICE USE ONLY P ____________ V ____________ A ____________