

MPF

ESB Staff Medical Provident Fund

P.O. Box 384, Rosbrien, Limerick

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HOSPITAL CLAIM FORM - DIRECT PAYMENT

For office use only

Membership Details

Name & Address of Member	Patient Name
	Relationship to member
	Telephone Number
	STAFF NUMBER

Ordinary Scheme

Extra Benefits Scheme

Nature of illness

Please give Clinical description as broad terms like "Back Problem", "Injury" or "see previous claim" are not acceptable.

Injury Section

THIS SECTION MUST BE COMPLETED IN ALL CASES WHERE A THIRD PARTY/OCCUPATIONAL INJURY IS BEING PURSUED (See Section 9 of Members Guide to Benefits)

Date & Place of Injury:	_____
Brief Description of Injury:	_____
Do you intend to make a Claim?	_____
Name & Address of Solicitor:	_____
<small>In consideration of the MPF discharging my medical expenses, to the extent of my cover limits, I/We undertake to the MPF to include these expenses as part of my claim against a third party(ies), I hereby irrevocably authorise the solicitor(s) representing me in making a claim to furnish to MPF an undertaking in the following words: "In consideration of the MPF discharging the medical expenses of my/our client(name). I/We hereby undertake to include as part of my/our client,s (name) the monies so paid out by the MPF (details of which are supplied to us by MPF) and subject to any order to the contrary, to repay to MPF out of the proceeds that come into our hands the new amounts recovered in respect of such payments made by the MPF"</small>	
Signature: _____	Date: _____
<small>Please sign here if injury is involved</small>	

I declare that to the best of my knowledge the foregoing statements are true in every respect and I authorise the doctors/hospitals to supply the information requested.

DECLARATION AND SIGNATURE

(Please ensure all above sections are completed to facilitate prompt payment)

Member's Signature: _____ Date: _____

P _____

V _____

A _____

MPF

TO BE COMPLETED BY ATTENDING CONSULTANT

Hospital Treatment Section

Please Tick One: **Private** **Semi Private** **Daycase** **Outpatient**

Admission Date: _____ Discharge Date: _____

Consultant & Medical Details

(to be completed by Consultant in overall charge)

Nature of symptoms: _____

Date of onset of symptoms: _____ Date you first saw patient with symptoms: _____

Description & details of specialist investigation and/or treatment: _____

Procedure Code(s): _____ Date(s) carried out: _____

Was an MRI Scan performed? _____ Date(s) carried out: _____

Was the patient transferred to/from any other hospital/establishment?
If so, please give details: _____

Is this illness related to any addictive condition? e.g. alcohol dependence, drug or substance abuse?
If so, please give details: _____

Is this illness related to any psychiatric condition?
If so, please give details: _____

Name and address of consultant in overall charge

Consultant's Signature: _____ Date: _____

**The front part of this form must be completed in full before invoices are attached and submitted
Non completion will result in Claim Forms being returned and will delay prompt payment of invoices.**