

LAYA HEALTHCARE

Money Smart Out-patient Claim Form

SECTION 1: MEMBER DETAILS

Member ID: **MEM-1004**

Patient Name: **Aoife Byrne**

Date of Birth: 1992-05-08

Address: 15 O'Connell Street, Limerick

Eircode: V94 EF78

Scheme: Money Smart 20 Family

SECTION 2: TREATMENT DETAILS

Form Type: Money Smart Out-patient Claim Form

Treatment Type: **Hospital In-patient**

Treatment Date: **2026-02-01**

Practitioner / Provider: St. Vincent's University Hospital

Practitioner Address: Elm Park, Dublin 4

Number of Days: 5

SECTION 3: FINANCIAL DETAILS

Total Cost (EUR): **EUR 100.00**

Receipt Attached: Yes

Payment Method: EFT to registered IBAN

IBAN (last 4): 7804

SECTION 5: DECLARATION

Member Signature: **Aoife Byrne**

I declare that the information given on this form is correct and complete.