

PLUTUS HEALTH, 60 NEWPORT ROAD, CARDIFF, SOUTH WALES, CF24 0YG  
Tel: 01633 266 152 Freephone: 0808 178 1179

# HOSPITAL IN-PATIENT CERTIFICATE

IT IS THE RESPONSIBILITY OF THE CLAIMING MEMBER OR REPRESENTATIVE(S) TO ENSURE ALL SECTIONS OF THE FORM ARE CORRECTLY COMPLETED **BEFORE** SUBMITTING TO THE HOSPITAL FOR CONFIRMATION. PLEASE NOTE THAT CLAIM DETAILS MAY BE CHECKED WITH THE TREATING HOSPITAL PRIOR TO RELEASE OF PAYMENT.  
HOSPITAL BENEFITS ARE PAID ON THE BASIS OF ONE ATTENDANCE PER HOSPITAL PER DAY.

Patient's full name: .....

Name of hospital: .....

Address:.....

Ward name: .....

.....

Date of admission: .....

..... Post code: .....

Date of transfer\*: .....

Telephone: .....

Date of discharge: .....

Email: .....

Date deceased: .....

Date of birth: .....

Date of claim if still an in-patient: .....

\*If transferred to a new hospital a new claim form will be needed

I confirm the above information is correct. **Signature of Member**.....

**THIS FORM MUST BE STAMPED AND SIGNED BY THE ADMITTING HOSPITAL**

FOR HOSPITAL

HOSPITAL STAMP

Signed on behalf of hospital: .....

STAFF USE ONLY

Position: .....