PLUTUS HEALTH, WHA House, Greenwood Close, Cardiff Gate Business Park, Cardiff, CF23 8RD
Tel: 01633 266 152 Freephone: 0808 178 1179

HOSPITAL DAY SURGERY CERTIFICATE

N.B. THIS FORM IS **NOT** TO BE USED FOR OVERNIGHT ADMISSIONS.
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: ……..……..

Address:……..……..……...

…….....

…….. Post code ...……..

Telephone: .....……..

Email: ……..…….

Date of birth: .....

Name of hospital: ……..……

Name of ward or dept: ……

Date of procedure: ……..……

Description of procedure: ……..…..

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

THIS FORM MUST BE STAMPED AND SIGNED BY THE ADMITTING HOSPITAL

FOR HOSPITAL STAFF USE ONLY

HOSPITAL STAMP

Signed on behalf of hospital: ……..…….....

Position: ……..…….....

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