PLUTUS HEALTH, WHA House, Greenwood Close, Cardiff Gate Business Park, Cardiff, CF23 8RD
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: …………………………………......

Address:……………………………………………………

……………………………………………………………

……………………...... Post code: ………………………

Telephone: ………………………………………………...

Email: ………………………………………………………

Date of birth: ……………………………………………

Name of hospital: ……………………………………

Ward name: …………………………………………

Date of admission: ………………………………......

Date of transfer*: ………………………………......

Date of discharge: …………………………………

Date deceased: ……………………………………

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 STAFF USE ONLY

HOSPITAL STAMP

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

Position: ……..…………………………………………...........

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