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:		Name of hospital:
Address:		Ward name:
		Date of admission:
Post	t code:	Date of transfer*:
Геlephone:		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
confirm the above infor	mation is correct. Signatur	e of Member
THIS FOR	M MUST BE STAMPED A	ND SIGNED BY THE ADMITTING HOSPITAL
FOR HOSPITAL	HOSPITAL STAMP	Signed on behalf of hospital:
STAFF USE ONLY		Position:
DI IITIIS HEAI TH	WHA House Greenwoo	nd Close Cardiff Gate Business Park Cardiff CE23 8RF
PLUTUS HEALTH	•	od Close, Cardiff Gate Business Park, Cardiff, CF23 8RD 152 Freephone: 0808 178 1179
	Tel: 01633 266 1	52 Freephone: 0808 178 1179
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Signed on behalf of hospital:

Position:

FOR HOSPITAL

STAFF USE ONLY

HOSPITAL STAMP