PLUTUS HEALTH, WHA House, Greenwood Close, Cardiff Gate Business Park, Cardiff, CF23 8RD
Tel: 01633 266152 Freephone: 0808 178 1179

HOSPITAL OUT-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 FORMS MAY BE CHECKED WITH THE 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: ……………………………………………

Patient's hospital no: ………………………………...

Name of hospital: …………………………………….

Department(s) attended: ………………………………

……………………………………………………………

Dates attended for treatment: ……………………

……………………………………………………………

……………………………………………………………

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

THIS FORM MUST BE STAMPED AND SIGNED BY THE RELEVANT OUT-PATIENT DEPARTMENT(S)

FOR HOSPITAL STAFF USE ONLY

HOSPITAL STAMP

No. of dates attended: ……………………………………

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

Position: ……………………………………………………

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