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.

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		'
Address:		·
		Department(s) attended:
	Post code:	
Telephone:		Dates attended for treatment:
Email:		
Date of birth:		
confirm the above inform	ation is correct. Signature	of Member
THIS FORM MUS	ST BE STAMPED AND SIG	GNED BY THE RELEVANT OUT-PATIENT DEPARTMENT(S)
FOR HOSPITAL	HOSPITAL STAMP	No. of dates attended:
STAFF USE ONLY	HOOF HAE GIAMII	Signed on behalf of hospital:
		Position:
T IS THE RESPONSIBILITY CORRECTLY COMPLETE	OF THE CLAIMING MEMBER D BEFORE SUBMITTING TO MAY BE CHECKED WITH TH	C-PATIENT CERTIFICATE R OR REPRESENTATIVE(S) TO ENSURE ALL SECTIONS OF THE FORM ARE THE HOSPITAL FOR CONFIRMATION. PLEASE NOTE THAT CLAIM FORMS E HOSPITAL PRIOR TO RELEASE OF PAYMENT. HE BASIS OF ONE ATTENDANCE PER HOSPITAL PER DAY.
Patient's full name: .		Patient's hospital no:
Address:		
	. Post code:	
I confirm the above infor	mation is correct. Signatur	e of Member
THIS FORM MUST	TBE STAMPED AND SIG	NED BY THE RELEVANT OUT-PATIENT DEPARTMENT(S)
FOR HOSPITAL	HOSPITAL STAM	P No. of dates attended:

Signed on behalf of hospital:

Position:

STAFF USE ONLY