

HOSPITAL CERTIFICATE

10380



Bolton & District
Hospital Saturday

- In order to ensure that the claim is processed without delay this certificate must be completed in full by the hospital and we must receive it within 3 months of the date of admission
- The Declaration and Access to Medical Reports Act 1988 must be signed by you

In Patient Claims

Patient's name	<input type="text"/>	Policy N°	<input type="text"/>
Patient's address	<input type="text"/>		
Email	<input type="text"/>	Contact N°	<input type="text"/>
Diagnosis	<input type="text"/>		
Date admitted	<input type="text"/>	Date discharged	<input type="text"/>
Was admission maternity related?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes give dates	<input type="text"/>
		Discharged weekends?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Parental Stay

Name of parent	<input type="text"/>	N° of nights	<input type="text"/>
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Day Surgery Claims

Patient's name	<input type="text"/>		
Patient's address	<input type="text"/>		
Diagnosis	<input type="text"/>		
Date of procedure	<input type="text"/>	Was the operation pre-booked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were theatre facilities used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was patient admitted overnight?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Authorisation: IMPORTANT - this form must be signed and stamped by the hospital

Signed	<input type="text"/>	Hospital Stamp
Position	<input type="text"/>	
Date	<input type="text"/>	

Payments

If you wish your payment to be paid directly into the bank then please enter your account details:

Account N°	<input type="text"/>	Sort Code	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>
Account Name	<input type="text"/>									

Once you have chosen this method we will pay all future claims into your nominated bank account.
As a consequence it will no longer be necessary to send you separate written notification of payment.

Deductions

If your premiums are taken from your wages, salary or pension please give the following information:

Company Name	<input type="text"/>		
Dept.	<input type="text"/>	Payroll/Pension N°	<input type="text"/>

Declaration and Access to Medical Reports Act 1988

I declare that the above information is correct. I understand that fraudulent claims will result in legal action and cancellation of my membership. I hereby authorise the relevant medical practitioner to divulge any information relating to the above claim.

Signature	<input type="text"/>	Date	<input type="text"/>
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Office Use Only

Date	<input type="text"/>
PUTD	<input type="text"/>
Type	<input type="text"/>
Credit/Chq	<input type="text"/>
Auth	<input type="text"/>
Ref	<input type="text"/>
£	<input type="text"/>

RETURN TO: Bolton & District Hospital Saturday Council, Ground Floor,
Regent House, Folds Point, Folds Road, Bolton BL1 2RZ