

Certificate of in-patient stay.

Patient name:

Patient address:

Membership number:

Authorisation number:

Hospital stay details

Date of admission:

D	D	M	M	Y	Y	Y	Y
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Date of discharge:

D	D	M	M	Y	Y	Y	Y
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Was the patient charged for treatment? Yes No

If YES, please give details of the charges made:

Hospital name:

Hospital official's signature:

Hospital official's name:

Date of signature:

D	D	M	M	Y	Y	Y	Y
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Hospital official's title:

NHS Hospital Official Stamp

Please return this completed form to us by:

post: PruHealth
Medical Management
Stirling
FK9 4UE

fax: 0800 096 4222