



CONFIRMATION OF SURGERY

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PATIENT'S NAME	MEMBERSHIP NO.
FULL ADDRESS	
EMAIL ADDRESS	

I certify that the surgery, treatment or procedure as approved, was performed and all particulars shown on this claim are true and correct. I authorise UniMed to obtain further medical information they may need in connection with this claim submitted by me or my listed dependants. UniMed may disclose information related to this claim to the Integrity Register for the purposes of the detection of fraudulent and suspicious conduct.

Signed by _____ Date _____
the patient (or parent/guardian where the patient is under 18 years old)