PROVIDER NO.

PARAMOUNT HEALTHCARE MANAGEMENT PVT LTD

Elite Auto House, 54-A, 2nd Floor, M. Vasanji Road, Mumbai – 400 093 Tel: 022 –40004219/216. Fax: 022 – 67021259/60

ADMISSION REQUEST NOTE Annexure A

PART A- TO BE FILLED IN BY TREATING CONSULTANT

Name: Shri/ Smt/Kum: _____Age: _____yrs. Sex: _____

Patient's Tel No. (Off) _____ Fax (if any) _____ Mobile no. _____ Resi. Tel _____

PHS ID. No: _____ Corporate Name/ Emp Code: _____

Name of Treating Doctor: _____ Doctor's Tel No: _____

Name Of Hospital / Nursing Home: _____

Name of Family Physician: _____ Tel No.: _____

Presenting Complaints: _____

History of Presenting complaints:_____

Duration of presenting complaints: _____

Relevant Clinical Findings:

_____

_____

_____

Relevant past history & treatment: _____

Investigation Reports (attach separate sheet): -_____

Provisional/Differential Diagnosis: _____

Proposed Treatment Plan (attach separate sheet): _____

_____

Particulars	Yes/ No	Since When
Hypertension		
IHD		
Osteoarthritis		
COPD/ Bronchial Asthama		
Any other Chronic Disorder		

Particulars	Yes/ No	Since When
Diabetes		
Heart Diseases (Date of First episode)		
Cancer		
Alcohol/Drug abuse		
Maternity cases: Gravida_____Para_____Living _____LMP_____		

In c/o Accidents, influence of alcohol / any other drugs: **Yes / No** **Whether MLC done: Yes / No**

Particulars	Details
Date of admission	
Approximate expenses	
Room Rent	
Investigation Charges	
Name of Implant	
Cost of Implant	

Particulars	Details
Approximate duration of stay	
Class of accommodation	
Doctor / Surgeon Fees	
OT Charges/ Anesthesia/ Medicines	
Package Rate	
Total Amount	

PART B – TO BE FILLED BY THE HOSPITAL AUTHORITIES

Paramount will not be held liable for the payment in the event of any discrepancy between the facts presented at the time of admission & in final documents submission.

Signature & Stamp of Treating Doctor: _____Rubber Stamp Of Hospital & Signature _____

PART C- TO BE FILLED UP BY THE INSURED

I have 'No Objection' to Paramount obtaining details of my treatment / collecting documents and also hereby authorize PHS to pay the hospital bill & reimburse itself / receive the amount from my claim receivable from my insurance company. If my claim is rejected, I/we (the patient) will pay for the hospital & related expenses should this authorization become null & void due to wrong and/ or misleading and/or incorrect information regarding the duration of ailments and/or other historical information regarding my (patients) health status/. I acknowledge and agree that information provided by me are true and up to the best of my knowledge.

Previous policy details –Policy No._____ Insurance Company: _____

Previous claim details Ailment: _____Date: _____Amount_____

Concurrent Policy details: _____Contact Info:_____

SIGNATURE/S.: ________________________________ Name: ____