|  |  |  |
| --- | --- | --- |
| **FINAL REPORT CASHLESS AL NO- 000000000000** | | |
| Hospital Name |  | |
|  | | |
| Patient Name |  | |
|  | | |
| DOJ | **00-Dec-0000** | |
|  | | |
| ILHC trigger |  | |
|  | | |
| DO Intimation | 00-00-2024 | Date of Visit- 00-00-2024 |
|  | | |
| DOA | 00-00-0000 | Pt. Admitted :- 00-00-0000 |
|  | | |
| Advance Paid Details | Not provided | Room Category – |
|  | | |
| IPDs Details /Findings / |  | |
|  | | |
| Insured statement |  | |
|  | | |
| Treating Dr. statement |  | |
|  | | |
| Home Visit if plan admission | No | |
|  | | |

|  |  |
| --- | --- |
| Other Findings | **As per Lab Report:-**  Dated on:-  **Completed Blood Count**  Hb  WBC  RBC  PLT |
|  | |
| Evidences attached / Uploaded in FT Yes or No |  |
|  | |
| FINAL RECOMMENDATION | **Remark:-** |