PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED (IRDA License No. 006)

[formerly known as PARAMOUNT HEALTH SERVICES (TPA) PVT.LTD]

Plot no.A-442, Road No-28,M.I.D.C Industrial Area, Wagale Estate, Ram Nagar, Vitthal Rukmani Mandir, Thane (W), Mumbai, Pin Code – 400 604

CLAIM ACKNOWLEDGMENT SHEET

Name of Insurer:	ABC Insurance Company	**PHS ID:**	LMN1234 --- Enter PHS ID
Insured Name:	XYZ --- Name of person to which policy belongs	**Employee No:**	XYZ890 --- Enter your Employee No.
Patient Name:	PQR --- Name of person who is covered in policy and claiming benefits for.	**Mobile No:**	XXXXXXXXXX
Policy No:	12345678 --- Enter policy number	**Phone (STD):**	+XX - XXXXXXXX
Name of Corporate:			
Type of Claim (To be ticked) :	Main Hospitalization / Pre-Post Hospitalization / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit	**E-Mail ID of primary insured:**	xyz@gmail.com

CLAIM DOCUMENT CHECK LIST

Sr. No	Description	Document Status(Y/N)	Remarks
1	IRDA Claim Form duly signed by the Insured & Hospital	Y	
	Part-A: Duly signed by the insured with Claimed amount, Mobile number & Email ID along with PHS ID	Y	
	Part-B: Duly signed and stamped by hospital	Y	
	Declaration form duly signed & stamped by the hospital in case treatment taken is under PPN/GIPSA hospitals.	N	
2	In case of No Intimation / Delay Intimation & Delay in submission of claim, a letter from insured is required stating reason for the same.	N	
3	Original Cancelled Cheque Leaf of Employee/Proposer with the Name of the Account Holder Printed on the Cheque Leaf.	Y	
4	ID Proof of Employee / Primary Insured- Any of one (Passport, Voter ID, Driving License, Or any Government Approved ID) . If Claim is above 1 lakh- PAN is mandatory with address Proof	Y	
5	ID Proof of Patient- Any of one (Passport, Voter ID, Driving License, Or any Government Approved ID)	Y	
6	Original detailed Discharge Summary as per IRDA Format / Day care summary from the hospital (in case of Day Care Treatment) / Death Summary (in Case of Death Claim)	N	
6.a	Copy of the Legal heir certificate (if the claim is for the death of the principle insured)	N	
6.b	Copy of Post Mortem Report & Death Certificate (In Accidental Death cases)	N	
7	Policy Copy **(if individual policy)**	N	
8	64VB Compliance Certificate **(If individual policy)**	N	
9	Original Final Hospital bill with cost wise breakup of each Item	Y	
10	Original Payment Receipt of Main Hospital bill (both Deposit / Refund)	Y	
10.a	Receipt Of Payments made at the Hospital by Credit Card : Please attach the Xerox Copy of the Credit Card Payment Slip as received from the Vendor	N	
11	Original copy of Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/ Mesh/ IOL	N	
12	Original bills, original Payment Receipts and investigation / Laboratory Reports	Y	
13	Original medicine bills specifying Patient Name and date of purchase along with supporting Prescriptions.	Y	
14	Original copy of First Consultation letter and subsequent Prescriptions.	Y	
15	Hospital Registration certificate issued by Competent authority as per Indian nursing council Act 1947 (If hospital not falls in GIPSA/PPN)	N	
16	**OTHER DOCUMENTS**		
16.a	Original copy of Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim)	N	
16.b	Original Sonography Report in case of Maternity Claim	N	
16.c	Original A-Scan Report along with IOL Sticker and Tax paid invoice in case of Cataract Claim	N	
16.d	Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case of Road Traffic Accident (RTA)	N	
16.e	A medical certificate from a doctor not less qualified than MD/MS confirming the diagnosis of critical illness along with the Investigation reports/Other related documents reflecting the critical illness diagnosis. (Critical Illness Cases)	N	
16.f	In case of claims where the insured has submitted documents to another insurance co./TPA, he needs to submit attested Photocopies of all the documents along with detailed claim settlement letter from the TPA and any unpaid bills and receipt for the same in originals.	N	

Claims Submitted by : Insured / Corporate / Agent / Broker / Insurer / Hospital

Claim Submitted by:	XYZ – The person who fills the claim form and submits the claim	**Mobile No.**	XXXXXXXXXX – Number of the person who will submit the claim
Date of Claim Submission:	DD/MM/YYYY HH:MM --- Format of Date & Time	**PHS Executive Name:**	Name of the person to whom you submitted the claim at PHS office.
Claim Submitted at:	PHS - (Location) / Help Desk – Enter location where you will submit the claim	**Signature:**	Sign of the person who submits the claim

Important Points to Remember:-

1. Please mark either √ or × against respective check box
2. Date of File Received will be considered as next working day for Claim Files picked up at Help Desk
3. Claim Need to be Submitted within 7 Working Days from Date of Discharge from Hospital
4. The above list of documents is indicative. In case of any other document requirement as specified by the Insurance Company, our document recovery team will contact you on receipt of your claim documents by us
5. Please visit us at www.paramounttpa.com to check Online Claim Status or download Paramount Mobile App
6. Member is advised to keep photocopies of all the papers since Insurer requires all the above documents in original. Documents once submitted will not returned unless approved & agreed by Insurer
7. Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED BY THE INSURED (To be Filled in block letters)

The issue of this Form is not to be taken as an admission of liablity

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.: 1 2 3 4 5 6 7 8 b) Sl. No/ Certificate no.

c) Company/ TPA ID No: L M N 1 2 3 4

d) Name: X Y Z SURNAME FIRSTNAME MIDDLENAME

e) Address: ADDRESS

City: MAHARASHTRA State:

Pin Code 4 0 0 0 0 1 Phone No: X x x x x x x x x x x Email ID: xyz@gmail.com

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☑ No b) Date of commencement of first Insurance without break: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☑ No Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance: : ☐ Yes ☑ No

f) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED: :

a) Name: PQR SURNAME FIRSTNAME MIDDLENAME

b) Gender Male ☐ Female ☑ c) Age years Y ☐ Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary insured: Self ☐ Spouse ☑ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)

f) Occupation Service ☑ Self Employed ☐ Home Maker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)

g) Address (if diffrent from above) :

City: State:

Pin Code Phone No: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION: :

a) Name of Hospital where Admited: HOSPITAL NAME

b) Room Category occupied: Day care ☑ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☑ Illness ☐ Maternity ☐ d) Date of injury / Date Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y f) Time: H H M H g) Date of Discharge: D D M M Y Y h) Time: H H : M H

I) If injury give cause: Self inflicted ☑ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ I) If Medico legal ☐ Yes ☐ No

ii) Reported to Police ☐ Yes ☑ No iii. MLC Report & Police FIR attached ☐ Yes ☑ No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

I. Pre -hospitalization expenses Rs. 7000

ii. Hospitalization expenses Rs. 110000

iii. Post-hospitalization expenses Rs. 500

iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs. 1000

vi. Others (code): Rs.

Total Rs. 195000

vii. Pre -hospitalization period: days 07

viii. Post -hospitalization period: days

b) Claim for Domiciliary Hospitalization: ☐ Yes ☑ No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily cash: Rs.

ii. Surgical Cash: Rs.

iii. Critical Illness benefit: Rs.

iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs.

vi. Others: Rs.

Total Rs.

Claim Documents Submitted - Check List:

- ☑ Claim form duly signed
- ☐ Copy of the claim intimation, if any
- ☑ Hospital Main Bill
- ☑ Hospital Break-up Bill
- ☑ Hospital Bill Payment Receipt
- ☑ Hospital Discharge Summary
- ☑ Pharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☑ Doctor's Prescriptions
- ☐ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.	xxxxxx	09/08/22		Hospital main Bill	11000
2.	xxxxxx	06/08/22		Pre-hospitalization Bills: Nos	7000
3.	xxxxxx	13/08/22		Post-hospitalization Bills: Nos	5000
4.	xxxxxx	15/08/22		Pharmacy Bills	10000
5.		DD/MM/YY			
6.		DD/MM/YY			
7.		DD/MM/YY			
8.		DD/MM/YY			
9.		DD/MM/YY			
10.		DD/MM/YY			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT::

a) PAN: ABCDEF5555 b) Account Number: 5xxxxxxxxxxxxxxxx

c) Bank Name and Branch: ABCDEFGHIJ

d) Cheque / DD Payable details: e) IFSC Code: xxxxxxxxxxxxxxx

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement shall be forfeited, I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

SECTION H

Date D D M M Y Y Y Y Place: Mumbai Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) Sl. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
c) Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printedin TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin code
SECTION B -DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-formrat
c) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the Insurance Company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
f) Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
1) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
b) Room category occupied	indicate the room category occupied	Tick the right option
c) Hospitalization due to	indicate reason of hospitalization	Tick the right option
d) Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh-mm- format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh-mm- format
I) If injury give cause	indicate cause of injury	Tick the right option
If Medico legal	indicate whether injury is medico legal	Tick Yes or No
Reported to Police	indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d) Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in rupees		
SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank account number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability

Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital:

a) Hospital ID:

c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)

c) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification:

f) Registration No. with State Code:

g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: FIRST NAME MIDDLE NAME SURNAME

b) IP Registration Number:

c) Gender: Male ☐ Female ☐

d) Age: Years Y Y Months M M

e) Date of birth: D D M M Y Y

f) Date of Admission: D D M M Y Y

g) Time: H H M M

h) Date of Discharge: D D M M Y Y

i) Time: H H M M

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ (k) If Maternity: i. Date of Delivery: D D M M Y Y ii) Gravida Status ☐☐☐

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

m) Total claimed amount

To BE FILLED BY HOSPITAL

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
I. Primary Diagnosis			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			Details of Procedure:		

To BE FILLED BY HOSPITAL

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to injury: ☐ Yes ☐ No I. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police ☐ Yes ☐ No

v. FIR No. vi. If not reported to police give reason:

To BE FILLED BY HOSPITAL

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of Photo ID Card of patient Verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

City: State: Pin Code: b) Phone No.: c) Registration No. with State Code:

To BE FILLED BY HOSPITAL

d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

SECTION F

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authrities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		

TO BE FILLED BY HOSPITAL

TO BE FILLED BY HOSPITAL