PARAMOUNT HEALTH SERVICES PVT.LTD.(IRDA Licence No. 006)

#10/1 Queen's Road. First Floor, Bangalore – 560 052. Tel: 22371234, 41131449 Fax: 41127990.

ADMISSION REQUEST NOTE

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 seperate sheet):

Provisional/Differential Diagnosis:

Proposed Treatment Plan (attach seperate sheet):

Particulars	Yes/No	Since When		Particulars	Yes/No	Since When
Hypertension				Diabetes		
IHD				Heart Diseases (Date of First episode)		
Osteoarthritis				Cancer		
COPD/ Bronchial Asthama				Alcohol/Drug abuse		
Any other Chronic Disorder				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		Particulars	Details
Date of admission			Approximate duration of stay	
Approximate expenses			Class of accomodation	
Room Rent			Doctor / Surgeon Fees	
Investigation Charges			OT Charges/ Anesthesia/ Medicines	
Name of Implant			Package Rate	
Cost of Implant			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 BY THE INSURED

I have 'No Objection' to Paramount obtaining details of my treatment / collecting documents and also hereby authorise 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 auhorization 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:

Save