

{LOGO}  
{NAME & ADDRESS OF THE HOSPITAL}

STANDARD  
**DISCHARGE SUMMARY**

- a. Patient's Name\* : \_\_\_\_\_
- b. Telephone No / Mobile No\* : \_\_\_\_\_
- c. IPD No : \_\_\_\_\_ d. Admission No: \_\_\_\_\_
- e. Treating Consultant/s' Name : \_\_\_\_\_
- a. Contact Numbers : \_\_\_\_\_
- b. Department/Specialty : \_\_\_\_\_
- f. Date of Admission with Time : \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_:\_\_\_\_ Hours
- g. Date of Discharge with Time : \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_:\_\_\_\_ Hours
- h. MLC No\* : \_\_\_\_\_ FIR No\*: \_\_\_\_\_
- i. Provisional Diagnosis  
at the time of Admission : \_\_\_\_\_
- j. Final Diagnosis at the  
time of Discharge : \_\_\_\_\_
- k. ICD-10 code(s) for Final Diagnosis\*: \_\_\_\_\_
- l. Presenting Complaints with  
Duration and Reason for Admission: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- m. Summary of Presenting Illness : \_\_\_\_\_
- \_\_\_\_\_
- n. Key findings, on physical  
examination at the time of admission: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- o. History of alcoholism, tobacco or  
substance abuse, if any : \_\_\_\_\_

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- p. Significant Past Medical and Surgical History, if any\* : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- q. Family History if significant/  
relevant to diagnosis or treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- r. Summary of key investigations  
during Hospitalization\* : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- s. Course in the Hospital including  
complications if any\* : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- t. Advice on Discharge\* : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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<b>Treating Consultant/ Authorized Team Doctor*</b>	Name	
	Signature	

<b>Patient/ Attendant *</b>	Name	
	Signature	

\* These are mandatory fields.

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### SUMMARY BILL FORMAT

Provider Name	.....	Bill Number	.....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name	XXXX Insurance Company Ltd	Date of Discharge	
Member Address		Bed Number	

### Billing Summary

Sl No	Primary Code	Particulars	Amount
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees'	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	0
Amount paid by member	.....0
Amount charged to Payer	0
Discount Amount	0
Service Tax	0
Amount Payable	0
Amount in Words	Rupees Zero Only

Patients Signature

Authorized Signatory

## **DETAILED BREAKUP FORMAT**

### **PART-I**

Provider Name	..... .....	Bill Number	..... .....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name		Date of Discharge	
Member Address		Bed Number	

### **Billing Details**

SI No	Date	Code	Particulars	Rate	Nos(Unit)	Amount
1		101001	General Ward Charges	500	1	500.00
2		401001	XXX medicine	50	2	100.00
3		401001	XXX Medicine – return	50	-1	-50.00