**{iname}**

**Health Claim of : {pname} Claim Number : {claimno}**

**Query to treating doctor**

Doctor kindly fill in the necessary details needed so as to help us process the claim of your Patient at the earliest.

1. Doctor, what were the complaints presented by {pname}to you during his admission / consultation on {doa}?
2. Since how long he suffering from the complaints?
3. Where were he consulting for the same problem before this admission? Please clarify.
4. What was the final diagnosis arrived? What were the investigations done to arrive these diagnosis?
5. Doctor, What was the line of treatment given? Kindly justify the prolonged admission.
6. What was the exact date & time of admission and discharge? Please mention.

Date of admission \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of discharge \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Kindly provide the Room No, Class of Accommodation and room rent / day.

Room No \_\_\_\_\_\_\_\_\_\_ Class of Accommodation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rent / day \_\_\_\_\_\_\_\_\_\_

No. of Days Accommodated \_\_\_\_\_\_\_ From To

1. Please clarify, does your hospital has in-house lab and pharmacy? If so, please provide GSTN Number fo your pharmacy.
2. Please mention the number of Beds, Rooms, Nurses and Duty Doctors available in your Hospital? Kindly Specify.

Doctor's Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**{iname}**

**Health Claim of : {pname} Claim Number : {claimno}**

1. Kindly justify the need of hospitalization. Why it can't be treated under OPD basis.
2. Have you been advised with OP medications / Treatment before getting admitted in the hospital? If so please provide the copy of same.
3. Kindly provide break-up for tretment charges.
4. Whether this patient treted under OPD basis? Kindly clarify.

1. Kindly provide a copy of a final bill and pre\_numbered payment receipt issued towards final bill.
2. Kindly provide a copy of Hospital Local body Registration certificate.
3. Please provide a copy of Hospital Tariff List for Room, ICU, Nursing and Professional Charges.
4. Kindly provide a copy of ICP, Temperature Chart, Drug Chart, IPD Register, OPD Register, Pharmacy sales register, Laboratory Nominal Register and Discharge summary.

**Note: Kindly provide a copy of local body registration certificate, IPD Nominal Register**

**Date :**

**Doctor's name : Doctor seal and signature**

***Doctor please provide a copy of the case sheet and the relevant OPD documents and the hospital tariff sheet for claim processing.***

***Please note: As per the Code of Medical Ethics Regulations, 2002 1.3.2 , if any request is made for medical records either by the patient/attendant/legal authorities involved, the document shall be issued within 72 hours***