

PROVIDER NO.
PARAMOUNT HEALTHCARE MANAGEMENT PVT LTD
 Elite Auto House, 54-A, 2nd Floor, M. Vasanji Road, Mumbai - 400 093 Tel: 022 - 40004219/216. Fax: 022 - 67021259/60

ADMISSION REQUEST NOTE Annexure A
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: _____ Tel No.: _____
 Name of Family Physician: _____
Presenting Complaints: _____
 History of Presenting complaints: _____
 Duration of presenting complaints: _____
 Relevant Clinical Findings: _____

 Relevant past history & treatment: _____
 Investigation Reports (attach separate sheet): - _____
 Provisional/Differential Diagnosis: _____
 Proposed Treatment Plan (attach separate sheet): _____

Particulars	Yes/ No	Since When
Hypertension		
IHD		
Osteoarthritis		
COPD/ Bronchial Asthama		
Any other Chronic Disorder		

Particulars	Yes/ No	Since When
Diabetes		
Heart Diseases (Date of First episode)		
Cancer		
Alcohol/Drug abuse		
Maternity cases: Gravid _____ Para _____ Living _____ LMP _____		

In c/o Accidents, influence of alcohol / any other drugs: **Yes / No** Whether I/LC done: **Yes / No**

Particulars	Details
Date of admission	
Approximate expenses	
Room Rent	
Investigation Charges	
Name of Implant	
Cost of Implant	

Particulars	Details
Approximate duration of stay	
Class of accommodation	
Doctor / Surgeon Fees	
OT Charges/ Anaesthesia/ Medicines	
Package Rate	
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 UP BY THE INSURED

I have 'No Objection' to Paramount obtaining details of my treatment / collecting documents and also hereby authorize 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 authorization 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: _____
 Date: _____ Amount: _____