GIPSA PPN NETWORK-DECLARATION BY PATIENT/Patient's ATTENDER

(PART-A & PART-B must be filled to make the declaration valid)

Name of the Hospital:……Date:……

Address: ……

PATIENT NAME: ----------AGE/SEX: ----------

IP NO: ----------UHID NO: ----------Mobile No of Patient: ----------

Date of Admission: ----------Time of Admission: ----------

Date of Discharge: ----------Time of Discharge: ----------

ADDRESS of the Patient: ----------

NAME OF THE ATTENDER: ---------- Relationship with the Patient: ----------

Mobile No. of Attender: ----------Address: ----------

PART-A (To be filled before admission)

A-1) Declaration regarding Insurance Policy (Strike off the option which is not applicable)

(i) ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

(ii) ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

Policy No/TPA card No: _____

Insurance Company: _____

A-2) whether patient opted for Eligible Room Category under Policy:

Yes / No

A-3) In case, policy holder wishes to avail better facility (Mention below the facility & provisional charges): Name of the Additional Facility/ Provision/ Procedure/ Treatment ……
…….. which costs Rs :…….
(In words: ……
……
……) only.

On my own option, I wish to avail above better facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed PPN tariff. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed PPN tariff rates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me.

Signature: ……
Name of the Patient/Patient's attendant:
Date/Proposed Date of Admission:
Time of Admission

Signature: ……
Name of the Hospital Representative &
Hospital Seal

PART-B (To be filled at the time of Discharge)

B-1)Amount Paid (if any) by the patient before admission in

Rs ……..towards……

(In words……)

B-2)Amount Paid (if any) by the Patient at the time of Discharge in

Rs ……..towards……

(In words……)

I have not Paid any extra Amount towards Patient Bill,other than that, mentioned above in B-1 & B-2.

Signature :……

Name of the Patient/Patient's attendant:
Date of Discharge:
Time of Discharge

Signature :……

Name of the Hospital Representative &
Hospital Seal