PPN NETWORK-DECLARATION BY PATIENT/PATIENT'S ATTENDANT

Name of the Hospital:.....Date :.....

Address:.....

PATIENT NAME (BLOCK LETTERS):..... 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 ATTENDANT :.....Relationship with the Patient:.....

Mobile No. of Attendant :..... Address:.....

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:_____

2) Whether patient opted for Eligible Room Category under Policy:**Yes / No**

3) In case, policyholder wishes to avail better facility:

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 peragreed PPN tariffrates 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 :..... Signature :.....

Name of the Patient/Patient's attendant: Name of the Hospital Representative &Hospital Seal :