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

Name of the Hospital:……..Date:……

Address:…….

PATIENT NAME(Block Letter):----------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 Pt:----------

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

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

As I attend to above mentioned patient,

1) I declare that **Patient HOLDS/ DOES'T HOLD** Insurance policy
(If Yes Provide **Policy No/TPA card No**: ----------)

2) Whether pt opted for Eligible Room Category under Policy: YES **( ) / NO( )**

3) I hereby **understand and agree** to the following:-

Name of the Additional Facility/ Provision/ Procedure/ Treatment ----------, which Costs Rs :----------(In words:---------- ----------)only.

I hereby agree to pay on my free will, after being explained in detailed 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 GIPSA approved tariff,** And if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse as per **GIPSA approved tariff only,** rest of the amount has to be borne by myself or patient only.

Name of the attender:
Signature:

Name of the witness/Hospital
Representative Seal & Signature: