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PRE - ADMISSION FORM / PRE-AUTHORIZATION

Patient Name [redacted] Age [redacted]

Principle Member Name [redacted]

Scheme name [redacted]

Admitting hospital [redacted] Date of Admission [redacted]

Diagnosis [redacted]

When was the ailment first diagnosed [redacted]

If pregnancy related state L.M.P [redacted]

If C/S state first YES [redacted] NO [redacted]

If first c/s state elective [redacted] Emergency [redacted]

What is the possible cause of the ailment [redacted]

Is the ailment congenital/malignant/chronic/recurring [redacted]

Operation required if any [redacted]

Nature of treatment given & Recommendations [redacted]

Estimated cost of treatment [redacted]

Estimated days in the hospital [redacted]

Doctors Name [redacted] Signature & stamp [redacted]

Date [redacted]