

## 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 : Ad	dress :
Declaration regarding Insurance Policy (Strike off the last of the	insurance policy:
(ii) Declaration when patient has insu	• •
I declare that I have following In	nsurance 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.
being explained in detail by the Hospital author above mentioned Additional Facility/Procedure above the agreed PPN tariff. Further, if I opt to	facility and I hereby agree to pay on my free will, after rity in my own and understandable language about the Treatment and associated cost of it, which is over and go for final bill reimbursement with insurance company, nly as per agreed PPN tariff rates and balance amount will
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:	Signature :  Name of the Hospital Representative & Hospital Seal :