



**GIPSA NETWORK-DECLARATION FORM
(To be filled by the Hospitals)**

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

Address:.....

PATIENT NAME/INSURED NAME (BLOCK LETTERS):..... AGE/SEX

(To be filled by the Insured/policy holder/Attendant)

1. Do you have an Insurance policy? YES/NO

If yes, then please select: New India/ United India/ National Insurance/ Oriental Insurance/others

Policy No _____

TPA Name _____

TPA card No: _____

2. Have you contacted TPA or Insurance Company for cashless facility? YES/NO

3) Whether patient opted for Eligible Room Category under Policy: YES/NO

If No, then kindly mention the opted room category:.....

On my own option, I wish to avail above 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 Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed tariff for the treatment. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed tariff for the treatment and balance amount will be borne by me / patient only.

I have also been explained that when room service of a category other 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/ patient only

Signature:.....

Name of the Patient/Patient's attendant:

Signature:.....

Name of the Hospital Representative & Hospital Seal:

Mobile No.....

E –Mail.....

PAN / Form 60:

Aadhar Card Number.....