

Chief Minister Advocate Welfare Scheme-Delhi

FOR REIMBURSEMENT & PRE-POST HOSPITALIZATION CLAIM PROCESS



SUBMISSION INSTRUCTION

All original documents and/or deficiency documents must be submitted through **Speed Post** only to the communication address mentioned below:



HEAD OFFICE:

HealthIndia Insurance TPA Services Pvt. Ltd.

ADDRESS:

4th Floor, Neelkanth Corporate IT Park,
406 to 412, Kirol Road,
Vidyavihar (West), Mumbai – 400086

★★★ CLAIM SUBMISSION CHECKLIST ★★★

Chief Minister Advocate Welfare Scheme (Delhi) – Reimbursement Claim Process

A HOSPITAL / MEDICAL DOCUMENTS



1. Duly filled and signed IRDA claim form
2. Original Discharge Summary / Transfer Summary / Death Summary (if applicable)
3. Original final hospital bill with detailed breakup of charges
4. Original payment receipts (deposit/final settlement receipt) with revenue stamp
5. Original investigation reports (ECG, USG, CT Scan, X-ray, blood tests, etc.)
6. All supporting imaging records (films, ECG strips, Doppler/Angiography CD, etc.)
7. Original pharmacy bills with valid prescriptions
8. Original indoor case papers / hospital treatment records (**mandatory**)

B HOSPITAL VERIFICATION DOCUMENTS



9. Hospital registration certificate (if hospital is small / unrecognized / private clinic)

C ACCIDENT / MEDICO-LEGAL CASES



10. MLC (Medico-Legal Certificate) / FIR copy (**mandatory** for accident cases)

D CLAIM PROCESSING & COMMUNICATION



11. Copy of intimation email / claim intimation proof
12. Complete contact details of insured and patient
13. Valid photo ID proof of patient
14. Clarification letter (if there is delay in submission of documents)
15. Full KYC documents of patient and insured
16. Contact details of claimant + email ID

E BANK & PAYMENT DETAILS



17. Original cancelled cheque (with printed name of primary member and IFSC code)

F MANDATORY IDENTITY REQUIREMENT



18. Copy of Aadhaar Card of patient (As per IRDAI Circular No. IRDA/SDD/MISC/CIR/248/11/2017)

G TIMELINES FOR SUBMISSION



19. Reimbursement claim documents must be submitted within 30 days from the date of discharge.
20. Pre-hospitalization and post-hospitalization expenses must be submitted within 7 days from the date of completion of treatment or discharge, as applicable.

H TPA INTIMATION RULES



21. Planned hospitalization: Inform the TPA at least 48 hours before admission.
22. Emergency hospitalization: Inform the TPA within 24 hours of admission (whichever is earlier).
23. Claim intimation: Should be done through via email only (frd@healthindiatpa.com).
24. Late intimation or delayed submission may lead to claim rejection, unless you can provide a valid and unavoidable reason for the delay.

I CUSTOMER SUPPORT



For any further assistance, please contact our customer care team with your HealthIndia TPA ID Card / TPA Member Code / Claim Number:

- 24x7 Toll Free Number: **1800-220-102**
- Mumbai Landline: **022-6613 1101 / 022-6613 1122**
- Senior Citizen Toll Free Number: **1800-226-970**

IMPORTANT NOTES

- ✓ **Family Definition:** Self (below 85 years), spouse, and up to two children (covered up to 25 years of age) are eligible for coverage. **Parents are not covered** under this scheme under any circumstances. Additionally, there is no top-up facility available under this welfare scheme.
- ✓ All documents must be original unless explicitly stated otherwise
- ✓ Incomplete documents may delay or reject the claim
- ✓ Keep scanned copies of the full set for your record
- ✓ **Submit only via registered post or tracked courier**

- ✓ **Submission of documents via email is not accepted**
- ✓ Photocopies, scanned copies, or duplicate documents are not permissible under the CMAWS scheme.
- ✓ All claims will be processed as per the applicable hospital tariff and approved discount rates. In cases where cashless benefits are not availed, any amount over and above the approved limits cannot be processed for reimbursement claims. **Kindly avail cashless benefits at all empanelled hospitals.**
- ✓ If any suspicious activity or documents are found, the claim file will be cancelled immediately, and all associated benefits will be **withdrawn with immediate effect.**



**SUBMIT ORIGINAL DOCUMENTS
VIA SPEED POST ONLY**

Timely submission ensures
quick and hassle-free processing.



Prepared By Mr. Bahl



**SPEED POST TODAY
SECURE YOUR CLAIM TOMORROW**

Chief Minister Advocate Welfare Scheme-Delhi

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A. Hospital / Medical Documents

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2. Original Discharge Summary / Transfer Summary / Death Summary (if applicable)
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7. Original pharmacy bills with valid prescriptions
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B. Hospital Verification Documents

9. Hospital registration certificate (if hospital is small / unrecognized / private clinic)

C. Accident / Medico-Legal Cases

10. MLC (Medico-Legal Certificate) / FIR copy (mandatory for accident cases)

D. Claim Processing & Communication

11. Copy of intimation email / claim intimation proof
12. Complete contact details of insured and patient
13. Valid photo ID proof of patient
14. Clarification letter (if there is delay in submission of documents)
15. Full KYC documents of patient and insured
16. Contact details of claimant + email ID

E. Bank & Payment Details

17. Original cancelled cheque (with printed name of primary member and IFSC code)

F. Mandatory Identity Requirement

18. Copy of Aadhaar Card of patient (*As per IRDAI Circular No. IRDA/SDD/MISC/CIR/248/11/2017*)

G. Timelines for Submission

19. **Reimbursement claim documents** must be submitted within **30 days from the date of discharge**.
20. **Pre-hospitalization and post-hospitalization expenses** must be submitted within **7 days from the date of completion of treatment or discharge**, as applicable.

H. TPA Intimation Rules

21. **Planned hospitalization:** Inform the TPA at least **48 hours before admission**.
22. **Emergency hospitalization:** Inform the TPA **within 24 hours of admission (whichever is earlier)**.
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24. Late intimation or delayed submission may lead to **claim rejection**, unless you can provide a **valid and unavoidable reason** for the delay.

I. Customer Support

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- All documents must be original unless explicitly stated otherwise
- Incomplete documents may delay or reject the claim
- Keep scanned copies of the full set for your record
- Submit only via registered post or tracked courier
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- All claims will be processed as per the applicable hospital tariff and approved discount rates. In cases where cashless benefits are not availed, any amount over and above the approved limits cannot be processed for reimbursement claims. Kindly avail cashless benefits at all empanelled hospitals.
- If any suspicious activity or documents are found, the claim file will be cancelled immediately, and all associated benefits will be withdrawn with immediate effect.

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED BY THE INSURED

(To be Filled in block letters)

The issue of this Form is not to be taken as an admission of liability

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

SECTION G

DETAILS OF PRIMARY INSURED:

a) Policy No.:

b) Sl. No/ Certificate no.

c) Company/ TPA ID No:

d) Name:

e) Address:

City:

State:

Pin Code

Phone No:

Email ID:

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Medicaclaim / Health Insurance:

b) Date of commencement of first Insurance without break:

c) If yes, company name:

Policy No.

Sum insured (Rs.)

d) Have you been hospitalized in the last four years since inception of the contract?

Date:

e) Previously covered by any other Medicaclaim /Health insurance :

f) If yes, company name:

DETAILS OF INSURED PERSON HOSPITALIZED: :

a) Name:

b) Gender

c) Age years

d) Date of Birth

e) Relationship to Primary insured:

f) Occupation

g) Address (if diffrent from above) :

City:

State:

Pin Code

Phone No:

Email ID:

DETAILS OF HOSPITALIZATION: :

a) Name of Hospital where Admitted:

b) Room Category occupied:

c) Hospitalization due to:

d) Date of injury / Date Disease first detected /Date of Delivery:

e) Date of Admission:

f) Time

g) Date of Discharge:

h) Time:

i) If injury give cause:

ii) Reported to Police

iii. MLC Report & Police FIR attached

j) System of Medicine:

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

i. Pre -hospitalization expenses

Rs.

ii. Hospitalization expenses

Rs.

iii. Post-hospitalization expenses

Rs.

iv. Health-Check up cost:

Rs.

v. Ambulance Charges:

Rs.

vi. Others (code):

Rs.

vii. Pre -hospitalization period:

days

viii. Post -hospitalization period:

days

b) Claim for Domiciliary Hospitalization:

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily cash:

Rs.

ii. Surgical Cash:

Rs.

iii. Critical Illness benefit:

Rs.

iv. Convalescence:

Rs.

v. Pre/Post hospitalization Lump sum benefit:

Rs.

vi. Others:

Rs.

Total

Rs.

Claim Documents Submitted - Check List:

Claim form duly signed

Copy of the claim intimation, if any

Hospital Main Bill

Hospital Break-up Bill

Hospital Bill Payment Receipt

Hospital Discharge Summary

Pharmacy Bill

Operation Theater Notes

ECG

Doctor's request for investigation

Investigation Reports (Including CT / MRI / USG / HPE)

Doctor's Prescriptions

Others

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT::

a) PAN:

b) Account Number:

c) Bank Name and Branch:

d) Cheque / DD Payable details:

e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited, I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) Sl. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin code
SECTION B -DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediciam / Health Insurance?	Indicate whether currently covered by another Mediciam / Health Insurance	Tick Yes or No
b) Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-format
c) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the Insurance Company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediciam / Health Insurance?	Indicate whether previously covered by another mediciam / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
f) Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
1) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	indicate the room category occupied	Tick the right option
c) Hospitalization due to	indicate reason of hospitalization	Tick the right option
d) Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh-mm- format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh-mm- format
I) If injury give cause	indicate cause of injury	Tick the right option
If Medico legal	indicate whether injury is medico legal	Tick Yes or No
Reported to Police	indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ Cash benefit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d) Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in rupees		
SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank account number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

CLAIM FORM - PART B
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

DETAILS OF HOSPITAL

a) Name of the hospital:
a) Hospital ID: c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)
c) Name of the treating doctor:
e) Qualification: f) Registration No. with State Code: g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:
b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years Months e) Date of birth:
f) Date of Admission: g) Time: h) Date of Discharge: i) Time:
j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity ☐ i) Date of Delivery: ii) Gravida Status:
l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:
e) If authorization by network hospital not obtained, give reason:
f) Hospitalization due to injury: ☐ Yes ☐ No I. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐
ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police ☐ Yes ☐ No
v. FIR No. vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- | | |
|--|--|
| ☐ Claim Form duly signed | ☐ Investigation reports |
| ☐ Original Pre-authorization request | ☐ CT/MR/USG/HPE investigation reports |
| ☐ Copy of the Pre-authorization approval letter | ☐ Doctor's reference slip for investigation |
| ☐ Copy of Photo ID Card of patient Verified by hospital | ☐ ECG |
| ☐ Hospital Discharge summary | ☐ Pharmacy bills |
| ☐ Operation Theatre Notes | ☐ MLC reports & Police FIR |
| ☐ Hospital main bill | ☐ Original death summary from hospital where applicable |
| ☐ Hospital break-up bill | ☐ Any other, please specify |

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital
City: State:
Pin Code: b) Phone No. c) Registration No. with State Code:
d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No
iii. Others:

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date:

Place:

Signature and Seal of the Hospital Authority:

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		