GOVERNMENT OF INDIA

AYUSHMAN BHARAT
NATIONAL HEALTH AGENCY

ANNEXURE I: PREAUTHORIZATION FORM

PART I (TO BE FILLED BY THE BENEFICIARY)			
Patient Name		Age	
Gender		Health Card No	
IP No		Case No	
Postal Address			
House No		Street Name	
Village/City/Town		Block	
District		Pin-code	
Patient Tel. No.		Mobile No	
Name of the referral PHC/Hospital		District	
PART II (TO BE FILLED BY THE HOSPITAL) ALL COLUMNS ARE COMPULSARY			
Hospital Details			
Name of the Hospital/Nursing Home		Tel No	
Address			
Online Case Sheet			
History of Present Illness			
History of Past Illness -			
Examination Findings			
Height		Weight	
BMI		Pallor	
Cyanosis		Clubbing of Fingers/Toes	
Lymphadenopathy		Edema of feet	
Malnutrition		Dehydration	
Temperature		Pulse Rate per minute	
Respiration Rate		BP Lt.Arm	
BP Rt. Arm			

Systematic Examination Findings		
Main Symptom Name	**Sub Symptom name**	**Symptom Name**

Investigation Details			
Investigations			
Patient Diagnosed By			
Doctor Name			
Patient Type			
Diagnosis			
Primary Diagnosis			
Diagnosis Description			
Plan of Treatment			
Category Name	**Procedure Type**	**Procedure Name**	**Units Doctor Name**

I hereby declare that I have not requested for the treatment of the same patient/treated the same patient earlier for the same procedure. And/or I hereby declare that this preauthorization request is in continuation of the earlier treatment given

Signature of Treating Doctor with seal

Admission and Financial Details

Admission Type:

Planned:

Date of Admission: