Su-Swastha Yojna

A Government of Sikkim Initiative

PREAUTHORIZATION FORM

This form must be filled and submitted for all planned admissions

PART I (TO BE FILLED BY THE BENEFICIARY)

First Name | Middle Name | Last Name

Date of birth D D M M Y Y Y Y | Relationship with Employee Self / Dependent

Gender ☐ Male ☐ Female ☐ Other | UHID/ Registration no. Provided by Hospital

Su-Swastha ID no.

Postal Address

Line 1 | Line 2

Line 3 | City Village/City/Town

District | Pin Code

Patient Mobile No. | Employee Mobile No.

I understand that the pre-authorization approval covers certain medically necessary part of treatment during the admission and exclusion as per Su-Swastha Terms and Conditions shall be borne by patient or family themselves.

Date D D M M Y Y Y Y | Signature of Employee/Patient

PART II (TO BE FILLED BY THE HOSPITAL) ALL FIELDS ARE MANDATORY

Hospital Details

Name of the Hospital / Nursing Home

Hospital ID

Tel No. | Email ID

Address

Line 1 | Line 2

Line 3 | City Village/City/Town

District | Pin Code

Medical Details

Type of Admission ☐ Medical ☐ Surgical ☐ Dental ☐ Day Care ☐ Maternity

Current Complaints

Relevant Causative Factors

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HISTORY OF PAST ILLNESS

Past diagnosis, past procedures, causative factors from past

Examination Findings

Height | Weight

BMI | Temperature | Pulse | Blood Pressure

General Examination

Systemic Examination

INVESTIGATION DETAILS

Investigations/tests

Diagnosis established by test

Doctor Name & Reg No.

Diagnosis

Primary Diagnosis

Relevant details of diagnosis

Plan of Treatment

Category Name: Medical

Procedure/Treatment Type

Procedure Name

Speciality & Admitting Doctor

I hereby declare that the pre-authorization request is in line with the medical treatment equirements of the above patient in view of the diagnosis and medical facts of the case.

Date D D M M Y Y Y Y

Signature of Treating Doctor with Seal

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ADMISSION AND FINANCIAL DETAILS

Admission Type ☐ Planned ☐ Emergency Planned Date of Admission D D M M Y Y Y Y

Financial Details

Package/Non-Package ☐ Package ☐ Non-Package

Name/Code of Package _____ Package Rate

Serial Number	Rate	Remarks
Anesthesia and OT charges		
Surgery charges		
Stay and investigations/ ward management charges		
Implants		
Medicines and consumables		
Exclusions		
PRE AUTH AMOUNT REQUESTED		

Signature with Seal

Date D D M M Y Y Y Y

Authorized Person's Name _____

Tel No. _____ Email ID _____