ಸುವರ್ಣ ಆರೋಗ್ಯ ಸುರಕ್ಷಾ ಟ್ರಸ್ಟ್

JYOTHI SANJEEVINI SCHEME

PROCEDURE CLAIM AND FEEDBACK FORM

Hospital Name …….

Patient Name: ……..…… ……. KGID No. : ……..

IP Registration No.: ……..., Ward availed ……..

DOA:…..... DOS:…….……DOD:…….……

Preauth Issue Date:……..……..……, Preauth No: …….....

Preauth Amount:……..……., Claimed Amount: ……..

Cost of Implants/Stents etc…….. Package Cost :……..

Total Cost : …… Amount payable by beneficiary, if any details……

Bill No: …….....Bill Date: ……Bill Amount:…….....

TREATMENT DETAILS

Procedure Code Approved:……Procedure Code Done:…….……..…….

Name of the procedure:…….……

Treating Doctor Name and phone No: …….…….

Diagnosis: ……..Signature……

FEEDBACK FORM

Shri/smt/Kum……..…..…… having KGID No.:……..……

From:…….……..… Taluk…….……District having treated under Jyothi Sanjeevini Scheme was discharged on……..

1. Free food given: YES / NO
2. Feed back from the patient:…….…….…….

……..……..……

Signature of the Beneficiary with Phone No.	Signature of the SAMCO & Phone No. with Seal	Signature of the AM with Phone No