

BIJU SWASTHYA KALYAN YOJANA (BSKY)**PRAUTHORIZATION FORM****PART I (TO BE FILLED BY THE BENEFICIARY)**

Patient Name	Age
Gender	Regd. No
Postal Address	
House No	
Village/City/Town	
District	
Patient Tel. 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:-
Name of Treating Doctor:	Doctors Telephone No-
Address	

Case Sheet(Case sheet to be enclosed)**History of Present Illness-****History of Past Illness -****Systematic Examination Findings**

Main Symptom Name	Sub Symptom name	Symptom Name

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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 Rt. Arm	BP Lt. Arm	

Investigation Details(Enclose documents)	
Investigations	
Patient Diagnosed By	
Doctor Name	
Patient Type	

Diagnosis	
Primary Diagnosis	

Plan of Treatment(Enclose clinical notes & Tumor board report in cancer treatment plan)						
Procedure Name	Procedure Code	Package Cost	Implant name	Implant Code	Implant Cost	Total Cost

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 . Invoice of Implant to be submitted during claim processing.

Name & Signature of Treating Doctor with seal