BIJU SWASTHYA KALYAN YOJANA (BSKY)

PREAUTHORIZATION 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**

BIJU SWASTHYA KALYAN YOJANA (BSKY)

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