SECTION – III

Hospital Admission Verification Report

Name of Patient: ____________________________ S/D/W/O: _________________________________

Hospital's Name: ____

Address: ____ Phone No. ______________________

Name of Attending Physician or Surgeon: ____

Reasons of Hospitalization: ____

DETAILS OF HOSPITALIZATION: TIME: _______ FROM: ________ TO: ___________

Room/ Ward No: _____________ Bed No: _______

DIAGNOSIS:

____

____

Details of Investigation / Operation / Treatment

Sr. #	Details	Charges (Rs.)

Please attach Hospitalization Bills (in Original).

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Signature of Administrator with Stamp