STAR MEDICAL OFFICER FVR (PAN INDIA)-REVISED.

Patient Name: _____ Claim No: _____

Date of Admission:_____

1.Field Visit Details:

Name of M.O.:		
Intimation Receipt Date & Time		
Field Visit Date & Time		
Person Interacted with **Insured / Hospital**		

2. Insurance Details:

Policy No/ Validity Period		
Policy Type		
ID No.	Verification of ID with Photo : Y/N	
Insured Name:		
Patient's Date of Birth:	Age:	Gender: M/F
Address:		

3. Hospital Details:

Name		NW/NNW
Address:		
Contact Person	Phone No.	
Proper Maintenance of Case Sheet: **Y/N**	Infrastructure:	**Adequate/Inadequate**
If Inadequate, Details:		
Accommodate Type:	Room Rent : Rs.	

4. Clinical Assessment Details:

Investigation Done:	**In house / Outsourced**
Provisional Diagnosis:	
Previous History of similar complaints : **YES/NO**	**Duration:**
If Yes, Details	
In case of accident:Alcohol Intake **Y/N**	
Provide MLC/FIR No.	

5. Medical History & Duration: Past or present:

SI.No	Disease	Duration	SI.No	Disease	Duration
1	DM		9	Respiratory	
2	HTN			BA ☐ COPD ☐	
3	Heart Disease		10	Glaucoma/Cataract	
4	Liver Disease		11	STD	
5	Renal Disease		12	OA	
6	Cancer		13	Previous Surgery if any	
7	Thyroid		14	Previous Hospitalization If any	
8	CVA/Stroke		15	Previous accident if any With details & date	
16	Others				

_____

Signature of Patient/Attendant

6. Medical History:

Source of Information: (ICP/Patient/Relative/hosp staff/doctor)	
Medical history:	
Treatment Given/Surgical Procedure done:	
Investigations done:	
Implant Cost: Rs. ☐	Description:
Hospital Estimate: Rs. ☐	Panel Doctor Recommendation: Rs.

Visiting MO Signature

AUTHORISATION TO STARHEALTH AND ALLIED INSURANCE CO., LTD

I have under gone/ am undergoing treatment for …… from (date) …….. in ……. Hospital. I hereby authorize M/s Star Health and Allied Insurance Company Ltd, who is my Health insurer to seek through the bearer of this authorization any medical information/records including ICP, from the hospital or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given. Kindly oblige.

Place:

Date:

…….
Signature of insured-patient.

CLAIM NO: _____ **PATIENT NAME:** _____

POLICY NO: _____