ANNEXURE 1
FORMAT OF EMPANELMENT FORM

APPLICATION FORM FOR NETWORK SERVICE PROVIDER

Objective of this document

This document forms part of (Insert Insurance Company/ TPA's) hospital empanelment process

This document is a self-assessment questionnaire which is completed by a hospital that wants to provide services to our customers

This should be completed and returned to

Name: _____

Address:

_____

_____

___

Note: By completing this document you are declaring that your hospital meets certain criteria as set out in the form.

APPLICATION FORM FOR NETWORK SERVICE PROVIDER

HOSPITAL INFORMATION

a) Name of the hospital

b) Address

City State

c) Phone number

d) Fax no.

e) PAN no

f) Registration number

g) Email address

h) Website

CONTACT DETAILS

a) **Chief executive of hospital**:

i.) Name

ii.) Phone number

iii.) Email address

b) Main point contact for TPA/ Insurance company:

i.) Name

ii.) Designation

iii.) Phone number

iv.) Email address

c) Insurance/ TPA coordinator:

i. Name

ii. Designation

iii. Phone number

iv. Email address

BANK DETAILS

a) Bank name and branch

b) Address

City State

c) Account number

d) 9 Digit number appearing on the MICR cheque

e) IFSC code

f) Payee name

TAX DETAILS

a) Are you exempt from tax deduction at source? Yes No
   i) If yes, please attach income tax registration & income tax exemption certificate
b) Service tax registration number:

Note: Additional information may be required

OWNERSHIP

a) Type (Only tick one)
   i. Government ii. Nonprofit iii. Private

TOTAL NUMBER BEDS

a) Room category wise
   i. General ii. Twin sharing iii. Single iv. Single AC
   v. Day care vi. ICU

LEVEL OF CARE

a) TYPE (Only tick one)
   i. Secondary + Single specialty ii. Secondary + Multi specialty
   iii. Tertiary + Single specialty iv. Tertiary+ Multiple specialty

b) List of specialties (Tick ALL that apply)
   i. Internal medicine ii. Cardiology iii. Nephrology iv. Pediatrics
   v. Pulmonology vi. Gastro-enterology vii. General surgery
   viii. Orthopedics ix. Gynecology x. Obstetrics
   xi. Oncology xii. Urology

c) Nurse bed ratio
   i. General ii. Twin sharing iii. Single iv. Single AC
   v. ICU

d) Availability
   i. Full time physicians

CLINICAL SERVICES

a) Emergency (Tick ALL that apply)
   i. Emergency room/ Minor OT
   ii. 24 hour ambulance service
   iii. Burns unit
   iv. Trauma centre

b) Outpatient services
   i. Number of consulting rooms
   ii. OPD working hours

c) Diagnostic facilities

Investigations: (Tick ALL that apply)

i.	Blood biochemistry	ii. Hematology		iii. Microbiology	
iv.	Cytology	v. Immunology		vi. Blood bank	
vii.	Radiology	viii. X-ray		ix. USG	
x.	CT Scan	xi. MRI		xii. Nuclear medicine	

Inpatient facilities
   i. Number of major operating rooms
   ii. Number of minor operating rooms
   ii. Cath lab facility

Pharmacy

   i. Day/ Night

INFRASTRUCTURE AND SUPPORT SERVICE (Tick ALL that apply)

i.	Waste disposal system	ii. CSSD		iii. Laundry service	
iv.	Power back up	v. Central gas supply			
vi.	Water purification/ filtration	vii. Disabled friendly			

COMPUTERIZATION (Tick ALL that apply)

i.	IT Connectivity	ii. Hospital Information Systems		iii. Digitisation of records	
iv.	Coding	v. IT enabled services			

CERTIFICATION (Requires photocopy of certification) (Tick ALL that apply)

i.	JCI accredited	ii. ISO certified		iii. NABH certified	

Any other certification (Please specify)_____

OUTCOME DATA (Does hospital collect data on the following?) (Tick ALL that apply)

i.	Inpatient mortality	ii. Neonatal mortality	
iii.	Perioperative mortality	iv. Surgical site infections	
v.	Hospital acquired infections	vi. Unplanned return to theatre filtration	
vii.	Unplanned readmissions	viii. Transfers to other hospitals	
ix.	Complications of anesthesia	x. Transfusion reactions	

CHECK LIST FOR ENCLOSURES

i. Tariff list
ii. Hospital brochure
iii. Copy of the hospital registration certificate with the local government authority
iv. Copy of certification (ISO/ NABL/ JCI/ Others)

DETAILS OF OFFICIAL WHO COMPLETED THIS FORM

Name of person | Mobile number

Designation | Email address

Authorised Signatory | Seal of Hospital