STAR MEDICAL OFFICER FVR (PAN INDIA) – REVISED

Patient Name: ______________________________ **Claim No:** ____________________

IN-PATIENT REGISTRATION NO: ______________ **Date of Admission:** ________________

1. Field Visit Details: **S.NO IN HOSPITAL IN-PATIENT REGISTER:** __________________________

Name of FVO:			
Intimation Receipt Date		Intimation Receipt time*	
Field Visit Date		**Field Visit Time***	

GET WELL SOON CARD handed over to the Patient: (✓) YES ☐ / NO ☐ – Reason*:-

2. Insurance Details:

Policy No/ Validity Period		
Policy Type		
ID No.	Verification of ID with Photo : **(✓) YES ☐ / NO ☐**	
Insured Name:	Occupation & Organization:	
Patient's Date of Birth:	Age:	Gender: M/F
Address:		
Information collected from - Insured / Hospital (✓)		

3. Hospital Details:

Name:		NW/NNW:	
Address:			
Contact Person	Phone No.		
Proper Maintenance of Case Sheet:		Infrastructure: **(✓)** Adequate ☐ / Inadequate ☐	
In Case of Non-Network Hospital Infrastructure Details:		**Treating Doctor Details** - Name : Qualification / Registration No:	
Registration no :		No of beds :	
OT availability :		No of beds in ICU/HDU :	
Specialties' available :		Accommodation Type **Available**:-	
Room Rent: Billed - Rs.__________ **Published as per hospital tariff- Rs.**__________		Accommodation Type **Availed**:-	
Whether Willing to convert to Network / Agreed Network Hospital : - If So, (✓) NW -☐ / ANH-☐			

4. RTA Details (In Case of Accident):

(A).Details of Accident: History of LOC / amnesia following the accident – If RTA -was the patient driving / pillion – Previous accident if any with details & date -	**(B).In case of fire accident / fall from height:** • Has it been reported to police – **Yes ☐ / No☐** • If not , reasons for not doing so – **If Yes, has MLC & AR Verified – MLC ☐, AR ☐** Declaration if any (details): Possibility of attempted suicide – **Yes ☐ / No☐**
Accident Register Details: Date & time of accident : Place of accident :	**AR NO:** **MLC/FIR No:**

5. Medical History & Duration: Health condition of the patient.

Specify if information was collected from patient / relative or hospital records.

S.No	Disease	Duration	S.No	Disease	Duration
1	DM		9	**Respiratory** BA ☐ TB ☐ COPD ☐	
2	HTN				
3	Heart Disease		10	Glaucoma/Cataract/RD	
4	Liver Disease, Jaundice Alcohol intake Drugs intake		11	STD	
5	Renal Disease		12	OA	
6	Cancer		13	Menstrual history/ LMP	
7	Thyroid /(Tremors intolerance to hot/cold)		14	Obstetric history / IF LSCS, LCB	
8	CVA/Stroke/TIA		15	**For Children Less than 10 years** • Birth history • Any NICU / Preterm care • Duration of NICU stay • Any birth hypoxia • Any neonatal convulsion • Developmental milestones	
16	Previous Surgery If any		17	Previous Hospitalization if Any	
18	Duration & history of present Illness		19	Others (if any)	

Health details of insured patient given above are true and given with my knowledge.
I have been explained the details in local/mother tongue language.

✍**Signature***: ______________________

Name:-

Date & Time :-

Relationship to the insured patient
(if patient is unable to sign):

HOSPITAL SEAL:

In Case Seal Not Obtained Mention the Reason

6. Treatment Cost Details :-

A. Procedure Cost:	**FVO Inputs:-**
B. Implant Cost:	**FVO Inputs:-**
C. Package Rate:	**FVO Inputs:-**

7. Documents/Reports verified (✓) (YES ☐ / NO ☐) **Collected: (YES ☐ / NO ☐)**

ICP	**YES ☐ / NO ☐**	IP register	**YES ☐ / NO ☐**
Drug Chart / TPR Chart	**YES ☐ / NO ☐**	Pre-Anesthetic Notes	**YES ☐ / NO ☐**
Investigation Reports	**YES ☐ / NO ☐**	OP Register	**YES ☐ / NO ☐**

8. Clinical Assessment Details:

Date of onset of illness with duration:
a.Provisional Diagnosis:
Previous History of similar complaints : **(✓) YES ☐ / NO ☐**
If Yes, Details Source of information:- **Snapshot taken & Uploaded : (✓) YES ☐ / NO ☐**
b.Initial Assessment Details: At the time of Admission:
c.Positive Investigations Details: All Investigations related to Illness taken After Admission (Including Investigations done in Outside Lab):
d.Treatment Details: Done / Planned – As per Hospital:

9. FVO's Observations / Suggestions:

a. PED if any, Source of Verification of PED :

Whether Snapshot taken & Uploaded : (✓) Yes ☐ No ☐

b. Line of Treatment :

c. Social Habits(Alcohol History/ Smoking / Tobacco Intake):

d. Any other comments:-

Points to Focus :-

FVO' **- 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.

Date & Time:-____________________ **PLACE:**________________________

CLAIM NO: ____________________ **POLICY NO:** ________________________

PATIENT NAME:____________________ **CONTACT NO:** ________________________

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Signature of insured-patient.