**ERICSON INSURANCE TPA PVT. LTD.**
4TH Floor, New Vijay Cinema Building, S.T. Road, Chembur, Mumbai-71
Website: www.ericsontpa.com E mail: care@ericsontpa.com
Tel. No: 022-25280280 Fax No: 022-25270200

## HOSPITAL INFORMATION PROFORMA

**NAME OF THE HOSPITAL: -** ______________________________________________

**ADDRESS: -** ______________________________________________
______________________________________________
______________________________________________

**LANDMARK: -** ____________________________ **DISCTRICT: -** ______________________

**STATE: -** ________________________________ **PIN CODE: -** ______________________

**TELEPHONE: -** _____________________________ **FAX: -** _________________________

**CONTACT PERSON MAIL ID:-** ____________________

**OWNERSHIP: -** **Individual** ☐ **Partnership** ☐ **Private Limited** ☐ **Others** ☐

**ADMINISTRATOR NAME: -** ______________________________________

**QUALIFICATION: -** ____________________________________________

**BED CAPACITY: -** _______ **HOSPITAL REGISTARION NO. :-** ________________

**SPECIALITY: - Single** ☐ **Multiple** ☐

**CONSULTANTS DETAILS:-**

| NAME OF THE CONSULTANT | QUALIFICATION | REGISTRATION NO. | SPECIALITY |
|---|---|---|---|
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**DETAILS OF DEPARTMENT AVAILABLE:-**

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**DETAILS OF DIAGNOSTIC SERVICES/EQUIPMENTS AVAILABLE: - PLS ATTACH COPY OF THE DETAILS OF THE SERVICES**

| | | | | |
|---|---|---|---|---|
| **LAB SERCVICES: -** | **YES** | ☐ | **NO** | ☐ |
| **RADIOALOGY: -** | **YES** | ☐ | **NO** | ☐ |
| **CARDIOLOGY: -** | **YES** | ☐ | **NO** | ☐ |
| **NEUROLOGY: -** | **YES** | ☐ | **NO** | ☐ |
| **GASTROENTEROLOGY:-** | **YES** | ☐ | **NO** | ☐ |
| **NUCLEAR MEDICINE: -** | **YES** | ☐ | **NO** | ☐ |
| **OTHERS IF ANY: -** | **YES** | ☐ | **NO** | ☐ |

**FACILITIES AVAILABLE:-**

| | | | |
|---|---|---|---|
| **1. OPERATION THEATRE** | **YES** ☐ | **NO** ☐ | **UNITS** _________ |
| **2. LABOUR ROOM** | **YES** ☐ | **NO** ☐ | **UNITS** _________ |
| **3. EMERGENCY WARD** | **YES** ☐ | **NO** ☐ | **UNITS** _________ |
| **4. BLOOD TRANSFUSION** | **YES** ☐ | **NO** ☐ | |
| **5. ICU** | **YES** ☐ | **NO** ☐ | **UNITS** _________ |
| **6. INHOUSE PHARMACY** | **YES** ☐ | **NO** ☐ | **UNITS** _________ |

**7. 24*7 DOCTOR/CONSULTANT AVAILABILITY** **YES** ☐ **NO** ☐

* **Kindly attach the hospital tariff copy with all the relevant details.**

* **Kindly attach the hospital registration certificate copy.**

* **Kindly attach the additional information brochure for the facilities available.**