NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

1). Lung abscess, Non Resolving – up to 10 days stay: M10 T4.1

1. Name of the Procedure:

   Lung Abscess, Non Resolving – up to 10 days stay

2. Indication: Lung abscess

3. Does the patient presented with Cough with copious expectoration/Fever: Yes/No
4. If the answer to question 3 is Yes, then is the patient having evidence of

   a). Localized collection of pus in the lungs in one or more cavities on X-Ray Chest and/or CT Scan: Yes/No (Upload X-ray Chest and/or CT Scan film)

   b). Hemogram including blood film examination, Blood Sugar, Urea, Creatinine and LFT test done: Yes/No (Upload reports)

   c). Sputum smear and culture, Sputum for AFB and Blood culture done: Yes/No (Upload Reports except for culture reports which can be submitted at the time of claim)

   d). ECG and/or2D-ECHO done to r/o cardiac abnormalities: Yes/No (Upload ECG and/or 2D- ECHO report)

   e). Bronchoscopy – Fiberoptic / Rigid : Yes/No (Upload report)-Optional

For Eligibility for Lung abscess – upto 10 days stay the answer to question 4a AND 4b AND 4c AND 4d must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

2). Pneumothorax (Large/Recurrent) - 10 days stay: M10 T4.2

1. Name of the Procedure:

   Pneumothorax (Large/Recurrent) - 10 days stay

2. Indication: Pneumothorax (Large/Recurrent)

3. Does the patient presented with acute pleuritic chest pain with shortness of breath : Yes/No

4. If the answer to question 3 is Yes, then is the patient having evidence of Presence of air / air and fluid in the pleural cavity on chest radiography; large (> 40% of hemithorax) or recurrent (more than once) on X-Ray Chest and/or CT Scan: Yes/No (Upload X-ray Chest and/or CT Scan film)

(Thoracoscopic examination- optional)

For Eligibility for Pneumothorax (Large/Recurrent) up to 10 days stay the answer to

question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

3). Interstitial Lung Diseases - 10 days stay: M10 T4.3

1. Name of the Procedure:

   Interstitial Lung Disease with up to 10 days stay

2. Does the patient have
   a. Continued Cough: Yes/No

      AND/OR

   b. Breathlessness: Yes/No

3. If the answer to questions 2a AND/OR 2b is Yes then is the patient having evidence of:

   a). Interstitial Lung Disease demonstrated on X-Ray chest/HRCT: Yes/No (Upload X-Ray chest/HRCT Report)

   b). SaO2<90% demonstrated on Pulse Oxymetry: Yes/No (Upload Report)

For eligibility for Interstitial Lung Disease with up to 10 days stay, the answer to questions 3a AND 3b must be Yes.

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

4). Pneumoconiosis – 10 days stay: M10 T4.4

1. Name of the Procedure:

   Pneumoconiosis – 10 days stay

2. Does the patient have history of occupational exposure to dust and presence of

   c. Progressive Breathlessness: Yes/No

      AND

   d. Cough: Yes/No

3. If the answer to questions 2a AND 2b is Yes then is the patient having evidence of Interstitial radiological infiltrates suggesting pneumoconiosis demonstrated on X-Ray chest/CT Chest: Yes/No (Upload X-Ray chest/CT Report)

For eligibility for Pneumoconiosis with up to 10 days stay, the answer to question 3

must be Yes.

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

5). Acute Respiratory Failure (without ventilator) – 10 days stay: M10 T4.5

1. Name of the Procedure:

   Acute Respiratory Failure (without ventilator) – 10 days stay

2. Does the patient have Respiratory failure (PaO_2 < 60 mmHg with / without $PaCO_2$ > 40 mmHg) due to any cause in a previously healthy patient or in the presence of a chronic lung disease (e.g. COPD, asthma, ILD, pneumoconiosis, neuromuscular diseases or any other): Yes/No

3. If the answer to questions 2 is Yes then is the patient having evidence of

   a. Sa_{02}<90% and PaO_2<60 mmHg demonstrated on ABG: Yes/No (Upload ABG Report)

   b. Chest Radiology X-Ray chest/CT Scan Chest done: Yes/No (Upload X-Ray Chest/CT Scan Report)

For eligibility for Acute Respiratory Failure (without ventilator) – 10 days stay, the answer to question 3a AND 3b must be Yes.

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

6). Acute Respiratory Failure (with ventilator) – 10 days stay: M10 T4.6

1. Name of the Procedure:

   Acute Respiratory Failure (with ventilator) – 10 days stay

2. Does the patient have Respiratory failure (PaO2 < 60 mmHg with / without PaCO2 > 40 mmHg) due to any cause in a previously healthy patient or in the presence of a chronic lung disease (e.g. COPD, asthma, ILD, pneumoconiosis, neuromuscular diseases or any other) not responding to standard treatment: Yes/No

3. If the answer to questions 2 is Yes then is the patient having evidence of

   a. PaO_2 < 60 mmHg and/or $PaCO_2$ > 40 mmHg demonstrated on ABG: Yes/No (Upload ABG Report)

   b. Chest Radiology X-Ray chest/CT Scan Chest done: Yes/No (Upload X-Ray Chest/CT Scan Report)

For eligibility for Acute Respiratory Failure (with ventilator) – 10 days stay, the answer to question 3a AND 3b must be Yes.

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

7). Bronchiectasis requiring hospitalization – 10 days stay: M10 T4.8

1. Name of the Procedure:

   Bronchiectasis requiring hospitalization – 10 days stay

2. Does the patient have Presence of chronic cough/purulent sputum and/or hemoptysis due to bronchial destruction with acute exacerbation requiring hospitalization.: Yes/No
3. If the answer to questions 2 is Yes then is the patient having evidence of

a. Radiological presence of Bronchiectasis demonstrated on X-Ray chest/Chest CT: Yes/No (Upload X-Ray report/Chest CT report)

b. Spirometry and other lung function tests including arterial blood gas assessment done: Yes/No (Upload Reports) - Optional

For eligibility for Bronchiectasis requiring hospitalization – 10 days stay, the answer to question 3a must be Yes.

I hereby declare that the above furnished information is true to the best of my knowledge.

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