NAME OF THE HOSPITAL: ____

16). Cost Of Each Coil: S10I12.2

1. Name of the Procedure: Cost Of Each Coil

2. Indication: Management of aneurysms

3. Does the patient presented with fainting or sudden loss of consciousness, seizure, vomiting, blurred vision, changes in speech, severe headache: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI, Angiogram: Yes/No (Upload reports)

5. If the answer to question 4 is Yes then is there evidence of coagulopathies: Yes/No

For Eligibility for Cost Of Each Coil the answer to question 5 must be NO

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

Treating Doctor Signature with Stamp

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