**Empanelled Hospital details for Registration at SCCL**

|  |  |
| --- | --- |
| Hospital Name |  |
| City |  |
| Specialities |  |
| Mobile No. \* |  |
| Email ID |  |
| Fax.No |  |
| Address |  |
| Contact Person Names with Mobile Number |  |
| GSTIN No |  |
| PAN No |  |

\* Mobile name specified is used for Login creation and SMS communication

Submit all details in the specified format to O/o Chief Medical Officer, Kothagudem