BILLING CARD

MH/ PRINT / 0007 / BILL / FO

Patient Name: Child.BATHKAN B
4/Male/MHM69889
30/09/2024/IPM2024000900
Dr.MEDWAY HOSPITAL

IP No. _____

Room No. ___

D.O.A. 30/9/24 Time 01:00pm

Rent Per Day 4000/-

TRANSFER DETAILS

Date	Time	From	To	Sister Signature
30/9/24	1pm	ER	Recovery room	Shanthi
1/10/24	8:30Am	Recovery	OT	Sirilakshmi
1/10/24	10 Am	OT	~~Recovery room~~ IWO	Jiji
1/10/24	12:30pm	IWO	Recovery	Jiji

OPERATION THEATRE

Date	01/10/24	OT No.	1
Surgeon	:	Start Time	9 Am
Asst. Surgeon	: DR Saravanan	End Time	9.15 Am
II Asst. Surgeon	:	Dis. Pack	:
III Asst. Surgeon	:	Diathermy	: used
Anaesthetist	: DR Santhikumar.	C-Arm	:
OT Nurse	:	Arthroscopy	:
Name of Surgery	: circumcision	Laproscopy	:
U S G done.		Sevoflurane / Isoflurane	:
		Inj. Fentanyl	:
		Others	:

MONITOR

Date	Start	Date	Disconnect
1/10/24	10:15Am	12:30pm	

INFUSION PUMP

Date	Start	Date	Disconnect

OXYGEN

Date	Start	Date	Disconnect
1/10/24	10.15Am.	12.30pm	

SYRINGE PUMP

Date	Start	Date	Disconnect

ALPHA BED / SCD PUMP

Date	Start	Date	Disconnect

VENTILATOR

Date	Start	Date	Disconnect

OPERATION THEATRE

Date	:	OT. No.	:
Surgeon	:	Start Time	:
I Asst. Surgeon	:	End Time	:
II Asst. Surgeon	:	Dis. Pack	:
III Asst. Surgeon	:	Diathermy	:
Anaesthetist	:	C-Arm	:
OT Nurse	:	Arthroscopy	:
Name of Surgery	:	Laproscopy	:
		Sevoflurane / Isoflurane	:
		Inj. Fentanyl	:
		Others	:

Date	LABORATORY

RADIOLOGY - ECG / ECHO / X-RAY / USG / CT / MRI / DRP / BIO-DOPPLER			

CBG			

CBG			

Date	PHYSIOTHERAPY

NEBULIZER			

NEBULIZER			

CONSULTANT NAME	Date	Date	Date	Date	Date	Date	Date
D. Saravana Baran.	7/10/24						

PHARMACY

OT DRUGS REPLACED : Total Bill amt. Rs. 9276.00.

BILL CLEARED :

RETURNS CHECKED : 22/10/24 12.29pm

AMBULANCE

Nil.

Other Procedures : (specify) :- OT clearance done

Admission Office :

Sister In-charge

Cashless - Final Approval

Date : 01-Oct-24
Time : 08:47 PM

Dear Sir/Madam,

Greetings from STAR Health!

We are writing with regard to your claim request for the below-mentioned insured patient, for the treatment of PARAPHIMOSIS:

Claim Intimation Number	:	CIR/2025/111111/0991441
Name of the Insured	:	BATHRAN B
Age / Gender	:	4 years 3 months / Male
Product Name	:	Star Comprehensive Insurance Policy
Policy Number	:	11230199013308
Policy Period	:	26-Oct-23 to 25-Oct-24
Date of Admission	:	30-Sep-24
Date of Discharge	:	01-Oct-24
Name of the Hospital and Location	:	MEDWAY HOSPITAL - CHENNAI - 600037

We acknowledge receipt of the final bill amount - Rs.28000/- for cashless treatment availed for the insured patient. Based on your latest request and the documents submitted, we have approved Rs. 28000/- on 01-Oct-24.

Please find below a summary with details:

Initial (Pre-Authorisation) Approved	Rs. 22400
Final Hospital Bill	Rs. 28000
Admissible Hospital Bill	Rs. 28000
Bill items not covered as per Policy Conditions (Refer Working Sheet)	
Amount Payable by STAR Health to Hospital from Admissible Hospital Bill(Refer Section F for details)	Rs. 28000
Amount Payable by Insured to Hospital from Admissible Hospital Bill (Refer Section D for details)	

Detailed Breakdown

Section	Description	Amount
A.	Final Hospital Bill	Rs. 28000

B.	Bill items not covered by Policy Conditions	
C.	Admissible Hospital Bill	Rs. 28000
D.	**Amount Payable by Insured to Hospital from Admissible Hospital Bill**	
1.	Non-payables as shown in the statement	
2.	Co-Pay as per policy conditions	
3.	Deductibles/Defined Limit	
4.	Sum Insured/ Sublimit Exceeded	
5.	Recovery of Discount(s) applied on Renewal	
6.	Balance premium installments to be paid by patient (wherever Insured has opted for installments	
D. Total		
E.	*Miscellaneous*	
1.	Network Hospital discount	
2.	Deviation from agreed package/SOC	
3.	Others	
E. Total		
F. **Amount Payable by STAR Health to Hospital** (C-D-E)		Rs. 28000

Amount Payable by STAR Health to Hospital: Rs. 28000 (Indian Rupees Twenty Eight Thousand Only)

Doctor Authorisation Remarks: MAXIMUM PAYABLE
NOTE ;subject to verification of bill as per agreed tariff during final settlement\

Detailed Working Sheet for Expenses not covered as per policy Terms and Conditions

S.No	Description	Claimed Amount	Expenses not covered as per policy Terms and Conditions against Hospital Bill	Proportionate deductions	Remarks

S.No	Description	Claimed Amount	Expenses not covered as per policy Terms and Conditions against Hospital Bill	Proportionate deductions	Remarks
1	a) ANH Package	28000			ANH
	Total	**28000**			