

Insurance



# BILLING CARD

MH/ PRINT / 0007 / BILL / FO

Patient Name

Baby.MUHAMMAD ZAEEM BASH

0'Male'MHM202406138

07/09/2024/1PM2024000798

D.O.A. 7/9/24 Time 11:00

IP No.

Dr.AIYSHA BEEVI

Room No.



Rent Per Day 4000/-

## TRANSFER DETAILS

Date	Time	From	To	Sister Signature
7/9/24	11:30 AM	ER	2nd floor 306	Shuj 3229

## 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 :

## MONITOR

Date	Start	Date	Disconnect

## INFUSION PUMP

Date	Start	Date	Disconnect

## OXYGEN

Date	Start	Date	Disconnect

## 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 :

[illegible]



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

[illegible]**CBG****CBG**[illegible]

## Date \_\_\_\_\_

## PHYSIOTHERAPY

[illegible]

## NEBULIZER

## NEBULIZER

7/9/24	2°					
8/9/24	3+1+1+2					
9/9/24	1+2+1+2					
10/9/24	2+1					







**PARAMOUNT HEALTH SERVICE & INSURANCE TPA PRIVATE LIMITED**  
(IRDA License No.006) Validity: From 21-03-2023 to 20-03-2026

Plot No.A-442,Road No-28.M.I.D.C Industrial Area,Wagale Estate,Ram Nagar, Vithal Rukhumani Mandir, Thane-400604 Tel-(022)-66620808, Fax No-66342754, E-mail contact.phs@paramounttpa.com.

Branch Code : 022

**Cashless Authorization Letter**  
(Part-D)

Date: 10/09/2024 03:43:16 PM

Claim Number: **6962783** (Please quote this number for all further correspondence)

Authorization is valid for admission up to 22/09/2024.

MEDWAY HOSPITALS Pe7, Pe7a, Block No-4, Bharathi Salai Mogappair West Nolambur, Chennai, Tamil Nadu-600037 Rohini Id : 8900080475298	Name of Insurance Company : The New India Assurance Company Ltd. Name of TPA : Paramount Health Services & Insurance TPA Pvt. Ltd. Proposer Name : NOUVFAL HAARIS Patient's Member : MUHAMMAD ZAEEM BASHEER ID/TPA/Insurer ID of the Patient : 42334633 Relation With Proposer : Son Corporate Name: DELOITTE SHARED SERVICES INDIA LLP
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Dear Sir /Madam,

This has reference to the last documents received for pre-authorization request on 10/09/2024 01:55:37 PM. We hereby authorize cashless facility as per details mentioned below:

Patient Name : MUHAMMAD ZAEEM BASHEER	Age : 1	Gender : MALE
Policy Number : 890000/34/23/04/00000563	Expected Date of Admission : 07/09/2024	
Policy Period : 11/02/2024-10/02/2025	Expected Date of Discharge : 10/09/2024	
Room category : SINGLE ROOM Category as per T&C of Policy Contract	Estimated Length Of Stay:3	
Provisional Diagnosis : Bronchiolitis	Proposed line of treatment : Bronchiolitis	

**Claim Remarks:**

**Authorization Details :-**

Claim No	Policy No	Date & Time	Reference number	Amount	Status	TAT
6962783	890000/34/23/04/00000563	09/09/2024 12:42	5447306	25000	Authorized	0 : 41
6962783	890000/34/23/04/00000563	10/09/2024 03:43	5450544	20908	Authorized	1 : 47

**Total Authorized amount:- Rs 45908 (FORTY FIVE THOUSAND NINE HUNDRED AND EIGHT)**

**Authorization Remarks:** STANDARD NON MEDICAL EXPENSES ARE DEDUCTED. CLAIM WILL BE SETTLED AS PER AGREED TARIFF POLICY T&C, IRRESPECTIVE OF AL AMOUNT ISSUED.

**Hospital Agreed Tariff:**

**I Package Case:**

Agreed Package Rate : NA

**II Non-package Case:**

i. Room Rent/day : NA

ii. ICU Rent/day : NA

iii. Nursing Charges/day : NA

iv. Consultant Visit Charges/day : NA

v. Surgeon's fee/OT/Anesthetist : NA

vi. Others (specify) : NA

**Authorization Summary:**

Total Bill Amount : 52533

\*Other Deductions : 3717

Discount : 2908

Co-Pay : 0

Deductibles : 0

Total Authorised Amount : 45908

Amount to be paid by insured : 3717

( Not to be collected from insured. )

Total = 52533

Approval = 45908

6625

Hospital Discount = 2908

3717

Advance = 5000

1283 Refund.  
1000  
2283

**\*Other Deduction Details :**

Sr.no	Description	Bill Amount	Deducted Amount	Admissible Amount	Deduction Reason
1	Medicine & Consumables charges	12465	1017	11448	EASYFIX Rs.188/-, INTRAFIX Rs.323/-, BANDAGE Rs.133/-, TEGADERM Rs.103/-, UNDERPAD Rs.270/-,
2	Miscellaneous charges	2700	2700	0	ADMINISTRATION CHARGE RS 700/-, DISINFECTANT CHARGE RS 2000/- DEDUCTED.

**Terms and Conditions of Authorization:**

1. Cashless Authorization letter issued on the basis of information provided in Pre- Authorization form. In case misrepresentation/concealment of the facts, any material difference/ deviation/ discrepancy in information is observed in discharge summary/ IPD records then cashless authorization shall stand null & void. At any point of claim processing Insurer or TPA reserves right to raise queries for any other document to ascertain admissibility of claim.
2. KYC (Know your customer) details of proposer/employee/Beneficiary are mandatory for claim payout above Rs 1 lakh
3. Network provider shall not collect any additional amount from the individual in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
4. Network Provider shall not make any recovery from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package)
5. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same or get the same refunded to the policyholder from the Network Provider and/or take necessary action, as provided under the MoU.
6. Where a treatment/procedure is to be carried out by a doctor/surgeon of insured's choice (not empanelled with the hospital), Network Provider may give treatment after obtaining specific consent of policyholder.
7. Differential Costs borne by policyholder may be reimbursed by insurers subject to the terms and conditions of the policy.

**DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM**

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals /Chemists supported by proper prescription.
3. Diagnostic Test Reports and Receipts supported by note from the attending Medical Practitioner /Surgeon recommending such Diagnostic supported by note from the attending Medical Practitioner / Surgeon recommending such diagnostic tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner/ Surgeon giving patient's condition and advice on discharge.
6. Please submit member paid receipt copy of the difference in AL amount and Hospital bill (excluding TPA discount) at the time of claim submission.
7. Invoice of implants.
8. Radiology Films.

Name of the Product - GROUP FLEXI MEDICLAIM-FLOATER and UIN No - PO70811710 Important Policy terms & conditions (sub-limits/co-pay/deductible etc)

Please note that the amount authorized is provisional and is subject to change based on the final bill and discharge summary and deduction of TDS as applicable.

**IMPORTANT POINT FOR CASHLESS PAYMENT:**

1. Final Bill & Discharge summary is mandatory for validation of authorized amount. In the absence of discharge intimation or final authorization all previous AL amount will stand null & void.
2. Insurer reserve the right to demand invoice and /or sticker of high value implant & consumables or medicine at the time of settlement. Non submission may lead to denial of entire claim or deduction of such amount during final settlement or possible recovery of such amount due to non-submission of invoice.
3. Radiology films and all original investigation report to be submitted in the claim file to avoid payment delay or recovery of such amount paid erroneously on account of non-submission.
4. Hospital is requested to submit the claim file within 2 days from patient discharge date for hassle free payment.

This is a system generated letter hence signature is not required.