

IN PATIENT SUMMARY BILL

UHID : MMH202481629
 IP No : IP2024002090
 Patient name : Mr.BABU N
 Age : 56 Y 7 M 19 D/Male
 Consultant Name : Dr.SRIRAM THANIGAI

Bill No : MMH/MH/IP202402071
 Bill Date : 26/09/2024
 DOA : 19/9/2024 8:17PM
 DOD :
 Entity Type : Insurance
 Entity Name : STAR HEALTH AND ALLIED INSURANCE

| S.No | Description | Amount |
|------|-----------------------------|---------------------|
| 1 | ADMINISTRATION CHARGES | ₹ 350.00 |
| 2 | BED CHARGES | ₹ 8,400.00 |
| 3 | DIET CHARGES | ₹ 500.00 |
| 4 | DUTY MEDICAL OFFICER CHARGE | ₹ 1,500.00 |
| 5 | EQUIPMENT | ₹ 7,500.00 |
| 6 | INJECTION CHARGES | ₹ 680.00 |
| 7 | LABORATORY | ₹ 9,419.00 |
| 8 | NURSING CHARGE | ₹ 1,600.00 |
| 9 | OPERATION THEATRE CHARGES | ₹ 17,000.00 |
| 10 | OTHER ADDITION | ₹ 21,913.00 |
| 11 | PHARMACY CHARGE | ₹ 122,353.00 |
| 12 | PHYSIOTHERAPY | ₹ 700.00 |
| 13 | PROCEDURE CHARGES | ₹ 450.00 |
| 14 | PROFESSIONAL TEAM FEES | ₹ 77,000.00 |
| 15 | RADIOLOGY | ₹ 3,200.00 |
| | | ₹ 272,565.00 |
| | | ₹ 262,565.00 |
| | | ₹ 272,565.00 |
| | | ₹ 10,000.00 |
| | | ₹ 0.00 |

Received Amount in Words : Ten Thousand Only

SUDHA
Authorised Signature

Payment History

| S.No | Receipt Date | Receipt Code | Payment Mode | Trans. Type | Received Amount |
|------|--------------|----------------------|--------------|----------------|-----------------|
| 1 | 9/21/2024 | MMH/MH/RECH202403696 | UPI | Advance Amount | 10,000.00 |

| Medical Claim | Claim No | Sanction Amount |
|----------------------------------|-------------------------|-----------------|
| STAR HEALTH AND ALLIED INSURANCE | CIR/2025/111100/0919664 | 262,565.00 |