INSURANCE

BILLING CARD

MH/ PRINT / 0007 / BILL / FO

Patient Name: Mrs.GURUVAMMAL R
65/Female/MHM202407095
21/09/2024/IPM2024000857
Dr.SIVAKUMAR D K

D.O.A. 21/9/24 Time 7.30PM

IP No. _____

Rent Per Day 4000/-

Room No. _____

TRANSFER DETAILS

Date	Time	From	To	Sister Signature
21/9/24	10 PM	ER	3RD Floor (304)	M. Devi/D543

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	:

Date	LABORATORY
21/9/24	⊙ CBC / ⊙ RFT & ECR / ⊙ Urine C/P (6714)
	⊙ Urine cfs (6715) ⊙ ABG (6716)
22/9/24	CBC / RFT / ~~Urine Micro Albumin~~ Lipid Profile (6742)
	◎ Urine · Micro Albumin (spot) (6746)
24/9/24	⊙ CBC / ⊙ RFT (6778)

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

21/9/24	① ECG (6716)	② Chest X-Ray	(6716)
23/9/24	① USG KUB (6762) done By Dr.		

CBG

21/9/24	1 + 1	(6785)	
22/9/24	1 + 1 + 1 + 1	(6785)	
23/9/24	1 + 1 + 1 + 1	(6741)	+ 1 (6785)
24/9/24	1 + 1 + 1	(6777)	

CBG

(13)

Date	PHYSIOTHERAPY

NEBULIZER

NEBULIZER

CONSULTANT NAME	Date	Date	Date	Date	Date	Date	Date
Dr. Sirakumar	21/9/24	22/9/24	24/9/24				
		3750					

PHARMACY	AMBULANCE
OT DRUGS REPLACED :	NIL
BILL CLEARED :	
RETURNS CHECKED :	

Other Procedures : (specify) :-

OT equipment –

Diet –

endoscopy/colonscopy –

Admission Officer :

Sister In-charge

Cashless Final Authorization Letter

Date: 9/24/2024 7:00:07 PM

Dear Provider Partner,
This has reference to the pre-authorization request submitted on 9/23/2024 12:09:04 PM
Claim Number:24092300564(Please quote this number for all further correspondence)

Authorization is valid for admission up to 9/28/2024 12:00:00 AM or expiry of the policy date whichever is earlier

Name of Hospital	: Medway Medical Centre	Name of Insuranc
Address	: No:2 United India Colony, 1st Cross street, Kodambakkam Chennai	Name of TPA
City	: Chennai	Proposer Name
District	: CHENNAI	Patient's Name
State	: Tamil Nadu	Insurer Id of the F
PinCode	: 600024	Relation with Prop
Rohini ID	: 8900080347533	

We here by authorize cashless facility as per details mentioned below :

Patient Name	: Guruvammal R	Age(Years)
Policy Number	: GMC016790100BWT	Gender
Policy Period	: 18-06-2024 - 17-06-2025	Expected Date of A
Room category	: Single	Expected Date of D
Eligible Room Category as per T&C of Policy Contract	: Single	Estimated length o
Provisional Diagnosis	: T2DM , HYPOGLTCEMIA	Proposed line of tr
Corporate Name	: Better World Technology Private Limited	Branch Code

Authorization Details:

Date & Time	Reference number
23/09/2024 -12:09	24092300564-1
24/09/2024 -19:00	24092300564-2

Total Authorized amount:- Rs:56162.00(Fifty Six Thousand One Hundred and Sixty Two)

Authorization Remarks :
Covered for active medical management. Final Approval amount is Rs.56162/-

Hospital Agreed Tariff:

I. Package case:
- i. Agreed Package Rate :

II. Non-package Case:
- i. Room Rent/day :
- ii. ICU Rent/day :
- iii. Nursing Charges/day :
- iv. Consultant Visit Charges/day :

v. Surgeon's fee/OT/Anesthetist :
vi. Others (specify) :

Authorization Summary

Total Bill Amount	: 68956.00
*Other Deductions	: 4405.00
Discount	: 2149.00
Co-Pay	: 6240.00
Deductibles	: 0.00
Total Authorized Amount	: 56162.00
Amount to be paid by insured	:

*Other Deduction Details:

S.no	Description	Bill Amount	Deducted Amount	Admissible Amount	De
1	Room Rent	12000.00	0.00	11400.00	
2	Consultation	9000.00	0.00	8550.00	
3	Medicines Supplied By Hospital	23280.00	1705.00	21575.00	170 wip
4	Labs/Bio/Micro/Pathology/Immuno/Histo/Cyto chemistry	21976.00	0.00	20877.00	
5	Others	2700.00	2700.00	0.00	270

Terms and Conditions of Authorization :

1. Cashless Authorization letter is 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 policy holder 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 em paneled with the hospital),Network Provider may give treatment after obtaining specific consent of policy holder.
7. Differential Costs borne by policy holder 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