INSURANCE

BILLING CARD

MH/ PRINT / 0007 / BILL / FO

Patient Name: Mr.VINEET JAIN
21/Male/MHM202407195
27/09/2024/IPM2024000882
Dr.VAISHNAVI GANESAN

D.O.A. 27/9/24 Time 8:00

IP No. _____

Room No. ___

Rent Per Day 4000/-

TRANSFER DETAILS

Date	Time	From	To	Sister Signature
27/9/24	8:40PM	ER	1st floor	Sharmi 3225

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
27/9/24.	Blood c/s (6914)
	• Widal (6915)
28/9/24.	• TC, PLT, SGOT, SGPT (6930)
29/9/24	• TC, Plat, SGOT, SGPT (6958)
29/9/24	Platelet Count (6973)
29/9/24	• Occult Blood (6975)
30/9/24	Platelet, TC, SGOT, SGPT (6999)

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

27/9/24	• ECG, Chest. xray (6946) done by Dr. Santhosh		
28/9/24	• USG Abdomen. (6942.)		

CBG

CBG

PHYSIOTHERAPY

Date	

NEBULIZER

NEBULIZER

CONSULTANT NAME	Date	Date	Date	Date	Date	Date	Date
DR. VAISHALI	28/9/24	30/9/24					

PHARMACY	AMBULANCE
OT DRUGS REPLACED : Bill Amount = 12065/-	
BILL CLEARED : 25/9/24	
RETURNS CHECKED :	

Other Procedures : (specify) :-

Admission Officer : 30.22.

30/9 1PM

Sister In-charge

Cashless - Final Approval

Date : 30-Sep-24
Time : 05:51 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 DENGUE:

Claim Intimation Number	:	CIR/2025/161126/0988148
Name of the Insured	:	VINEET JAIN
Age / Gender	:	21 years 9 months / Male
Product Name	:	Family Health Optima Insurance Plan
Policy Number	:	11240724964810
Policy Period	:	24-Feb-24 to 23-Feb-25
Date of Admission	:	27-Sep-24
Date of Discharge	:	30-Sep-24
Name of the Hospital and Location	:	MEDWAY HOSPITAL - CHENNAI - 600037

We acknowledge receipt of the final bill amount - Rs.35687/- for cashless treatment availed for the insured patient. Based on your latest request and the documents submitted, we have approved Rs. 22839/- on 30-Sep-24.

Please find below a summary with details:

Initial (Pre-Authorisation) Approved	Rs. 10000
Final Hospital Bill	Rs 35687
Admissible Hospital Bill	Rs. 25376
Bill items not covered as per Policy Conditions (Refer Working Sheet)	Rs. 10311
Amount Payable by STAR Health to Hospital from Admissible Hospital Bill(Refer Section F for details)	Rs. 22839
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. 35687

B.	Bill items not covered by Policy Conditions	Rs. 10311
C.	Admissible Hospital Bill	Rs. 25376
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	Rs. 2537
2.	Deviation from agreed package/SOC	
3.	Others	
E. Total		Rs. 2537
F. **Amount Payable by STAR Health to Hospital** (C-D-E)		Rs. 22839

Amount Payable by STAR Health to Hospital: Rs. 22839 (Indian Rupees Twenty Two Thousand Eight Hundred and Thirty Nine Only)

Doctor Authorisation Remarks: maximum paid after deducting non payables.
subjective verification done as per soc at the time of 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
1	Room Rent(Inclusive of GST) & Nursing charges	7500			

S.No	Description	Claimed Amount	Expenses not covered as per policy Terms and Conditions against Hospital Bill	Proportionate deductions	Remarks
2	Professional Fees (Surgeon, Anastheist, Consultation charges etc)	2400			
3	Investigation & Diagnostics	5950			
4	Medicines and Consumables	14137	4611		Non medical items deducted
5	Others	5700	5700		Dmo, admin
	Total	**35687**	**10311**		

Total = 35687.

Approval = 22839

12848.

Hospital Discount = 2537

10311

Advance = 5000

5311/- to pay