INSURANCE

BILLING CARD

MH/ PRINT / 0007 / BILL / FO

Mr.VIGNASH D
35/Male/MHM202407252
30/09/2024/IPM2024000893
Dr.BALAMURUGAN.S

Patient Name _____

IP No. _____

Room No. 112

D.O.A. 30/9/24 Time 10.45 am

Rent Per Day 4000/-

TRANSFER DETAILS

Date	Time	From	To	Sister Signature
30/9/24	1.30pm	ER	1st Floor 112	3198
30/9/24	6.10pm	1st Floor	OT	3198
30/9/24	7.30pm	OT	ER 1st FLOOR	Anitha 3214

OPERATION THEATRE

Date	: 30/9/2024	OT No.	: 1
Surgeon	: Dr. Balamurugan	Start Time	: 6.30pm
Asst. Surgeon	:	End Time	: 7.00pm
II Asst. Surgeon	:	Dis. Pack	:
III Asst. Surgeon	:	Diathermy	: used
Anaesthetist	: Dr. ~~SENTHIL KUMAR~~	~~C Arm~~	: Instrument 1000. Rs.
OT Nurse	: Bavani	Arthroscopy	:
Name of Surgery	: Haemorrhoidectomy	Laproscopy	:
		Sevoflurane / Isoflurane	:
under spinal anaesthesia		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
30/9/24	Specimen Send to main medway Hospital (7045)

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

CBG

2019 M (30/8)

CBG

Date

PHYSIOTHERAPY

NEBULIZER

NEBULIZER

CONSULTANT NAME	Date	Date	Date	Date	Date	Date	Date
DR. BALAMURUGAN.	30/9/24	1/9/24					

PHARMACY	AMBULANCE
OT DRUGS REPLACED : Total Bill Amt. RS. 5938.00	
BILL CLEARED :	
RETURNS CHECKED : 2245 Oct 1 12.51pm	

Other Procedures : (specify) :-

Clearance ok: Haemorrhoids + fissurectomy with low. fistulectomy.

Prof 30/9/24.

Diet -

Admission Officer :

Sister In-charge

Cashless - Final Approval

Date : 01-Oct-24
Time : 05:34 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 HAEMORRHOIDS AND FISSURE IN ANO:

Claim Intimation Number	:	CIR/2025/111113/0997672
Name of the Insured	:	D.VIGNASH
Age / Gender	:	35 years 3 months / Male
Product Name	:	Star Comprehensive Insurance Policy
Policy Number	:	11230038425806
Policy Period	:	31-May-24 to 30-May-25
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.74750/- for cashless treatment availed for the insured patient. Based on your latest request and the documents submitted, we have approved Rs. 74750/- on 01-Oct-24.

Please find below a summary with details:

Initial (Pre-Authorisation) Approved	Rs. 10000
Final Hospital Bill	Rs. 74750
Admissible Hospital Bill	Rs. 74750
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. 74750
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. 74750

B.	Bill items not covered by Policy Conditions	
C	Admissible Hospital Bill	Rs. 74750
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. 74750

Total = ₹4750
Approved = ₹4750
0
Advance = 5000 refund

Amount Payable by STAR Health to Hospital: **Rs. 74750 (Indian Rupees Seventy Four Thousand Seven Hundred and Fifty Only)**

Doctor Authorisation Remarks: MAX PAID

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	a) ANH Package	74750			As Per Anh