INSURANCE

BILLING CARD

MH/ PRINT / 0007 / BILL / FO

Patient Name : Mrs.KALPANA
33/Female/MHM202407345
11/10/2024/IPM2024000964
Dr.SARALA /

IP No. _____

Room No. ___

D.O.A. 11/10/24 Time 8:30

Rent Per Day 4000/-

TRANSFER DETAILS

Date	Time	From	To	Sister Signature
11/10/24	9PM	BP 3rd Floor (306) OT	3rd Floor (306) OT	J. [illegible] 3222
12/10/24	6.45			[illegible] 3169
12/10/24	8.30 AM			

OPERATION THEATRE

Date : 12/10/24
Surgeon : DR. SARALA.
I Asst. Surgeon :
II Asst. Surgeon :
III Asst. Surgeon :
Anaesthetist : DR. PAUL PRAVEEN
OT Nurse : VAIANTHA
Name of Surgery : ELECTIVE LSCS AND (BT) SIDE
DOB : 12/10/24. WEIGHT : 3.63 Kg. ST.
BABY : GIRL BABY. TIMING : 7.24 AM
VISA

OT No. : OT - 1
Start Time : 7.00 AM
End Time : 8.00 AM.
Dis. Pack :
Diathermy :
C-Arm :
Arthroscopy :
Laproscopy :
Sevoflurane / Isoflurane :
Inj. Fentanyl : 2 ML USED.
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**

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

CBG

CBG

PHYSIOTHERAPY

Date	

NEBULIZER

NEBULIZER

CONSULTANT NAME	Date	Date	Date	Date	Date	Date	Date
Dr. Sarala	12/10/24	13/10/24	14/10/24				

PHARMACY	AMBULANCE
OT DRUGS REPLACED : Bill amount = 26374/-	
BILL CLEARED :	
RETURNS CHECKED :	

Other Procedures : (specify) :- OT clearance done 30/12.

1. CATHETERIZATION PROCEDURE DONE OT ON 12/10/24

Catheter removed on 13/10/24 @ 5PM

Admission Office

Sister In-charge

Cashless Authorization Letter (40181968)
(Please quote this reference number in all future correspondence)

E-card | Claims | Plan hospitalization | Hospitals

Medi Assist

Medi Assist Insurance TPA Pvt. Ltd

XAP40181968

Date :14 Oct 2024

To,

The Administrator / Medical Superintendent,
Medway Hospital,
NO PC7 & PC7A, BLOCK 4, BHARATHI SALAI, NOLAMBUR, MOGAPPAIR WEST, CHENNAI 600037
Hospital ID: (298883)
Rohini Id: 8900080475298

Dear Partner,

With reference to your request (40181968) for final cashless pre-authorization, we here by authorize INR 46000 against your final bill amount INR 46000. The details of the pre-authorization are as follows.

Patient Details

Patient Name	D Kalpana
Relation to Primary Beneficiary	Spouse
Age	32
Gender	F
Insurance Company	The New India Assurance Co. Ltd
Medi Assist ID	5129359438
Policy Holder	EY Global Delivery Services India LLP_TN_NON_SEZ
IP No	
Policy No	87000034240400000058_TN_NON_SEZ
Policy/Plan Period	01 Apr 2024 to 31 Mar 2025
Primary Beneficiary	K N Karthick
Insurer Claim No	TP00387000024900281269
Insurer Member ID	MEMBER1905

Treatment Details

Provisional Diagnosis	Encounter for cesarean delivery without indication
Expected/Actual Date Of Admission	11 Oct 2024
Treating Doctor	SARALA
Procedure / Treatment Planned	Caesarean section (LSCS)
Estimated/Actual Date of Discharge	14 Oct 2024
Room Category Occupied	Single private room
Length Of Stay	3
Eligible Room Category	

Total Authorized amount Rs 46000 (Forty Six Thousand).

Authorization Remarks :

Final processed

Note: If Top Up is available and applicable as per policy conditions, Top Up claims will be processed and additional amounts will be approved along with base amount as per your benefit.

Authorization Summary

Total bill amount (INR)	46000
Other Deductions(INR)*	0
Deductibles (INR)	0
Total Authorized Amount(INR)	46000
Amount to be paid by Insured (INR)	0