INSURANCE

BILLING CARD

MH/ PRINT / 0007 / BILL / FO

Mrs.JAYANTHI S
42/Female/MHM202407456
10/10/2024/IPM2024000956
Dr.VIVEKRAAJAN K

Patient Name
IP No.
Room No.

D.O.A. 10/10/24 Time 11:00

Rent Per Day 2500/-

TRANSFER DETAILS

Date	Time	From	To	Sister Signature
11/10/24	12.30pm	ER	III rd floor	M Kanimozhi/3/24
12/10/24	1 Pm	Third Floor	OT	
12/10/24	2.30pm	OT	3rd Floor	Sroop 3171

OPERATION THEATRE

Date : 11/10/24
Surgeon : DR VIVEKRAJAN
I Asst. Surgeon :
II Asst. Surgeon :
III Asst. Surgeon :
Anaesthetist : DR VIKRAM S
OT Nurse : Jaison
Name of Surgery : Tympanoplasty c mastoidectomy
↓ GA done

OT No. : 01
Start Time : 1.30 PM
End Time : 2.30 PM
Dis. Pack :
Diathermy :
C-Arm :
Arthroscopy :
Laproscopy :
Sevoflurane / Isoflurane :
Inj. Fentanyl : 2ml used
Others : out side monitor are arranged by DR

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			

Date	PHYSIOTHERAPY

NEBULIZER			

NEBULIZER			

CONSULTANT NAME	Date	Date	Date	Date	Date	Date	Date
Dr. Vivek Rajan (ENT)	11/10/22						

PHARMACY	AMBULANCE
OT DRUGS REPLACED : Bill Amount = 10526/-	
BILL CLEARED :	
RETURNS CHECKED :	

Other Procedures : (specify) :- OT clearance done 30/22

clearance OK. → fess with septoplasty Mastoidectomy & tympanoplasty

11/10/22

Admission Officer:

Sister In-charge

PARAMOUNT HEALTH SERVICE & INSURANCE TPA PRIVATE LIMITED
(IRDA License No.006) Validity: From 21-03-2023 to 20-03-2026

Plot No.A-442,Road No-28,M.I.D.C Industrial Area,Wagale Estate,Ram Nagar, Vitthal Rukhumani Mandir, Thane-400604 Tel-(022)-66620808. Fax No-68342754, E-mail contact.phs@paramounttpa.com.

Branch Code [illegible]

Cashless Authorization Letter
(Part-D)

Date: 12/10/2024 06:38:08 PM

Claim Number: **7031356** (Please quote this number for all further correspondence)

Authorization is valid for admission up to 12/10/2024.

MEDWAY HOPSITALS Pc7, Pc7a, Block No-4, Bharathi Salai Mogappair West Nolambur,Chennai,Tamil Nadu-600037 Rohini Id : 8900080475298	Name of Insurance Company :National Insurance Company Ltd.
	Name of TPA : Paramount Health Services & Insurance TPA Pvt. Ltd.
	Proposer Name : GOKULDAS SURESH
	Patient's Member : S JAYANTHI
	ID/TPA/Insurer ID of the Patient : 38075382
	Relation With Proposer : Wife
	Corporate Name: HAIER APPLIANCES (INDIA) PVT. LTD.

Dear Sir /Madam,
This has reference to the last documents received for pre-authorization request on 12/10/2024 05:18:26 PM. We hereby authorize cashless facility as per details mentioned below:

Patient Name : S JAYANTHI	Age : 42 Gender : FEMALE
Policy Number : 340100/50/24/10000420	Expected Date of Admission : 10/10/2024
Policy Period : 08/07/2024-07/07/2025	Expected Date of Discharge :12/10/2024
Room category : Twin sharing room Category as per T&C of Policy Contract	Estimated Length Of Stay:2
Provisional Diagnosis : Left Chronic Otitis Media With Central Perforation With Mastoiditis With Dns	Proposed line of treatment : Left Chronic Otitis Media With Central Perforation With Mastoiditis With Dns

Claim Remarks:

Authorization Details :-

Claim No	Policy No	Date & Time	Reference number	Amount	Status
7031356	340100/50/24/10000420	11/10/2024 12:34	5525536	40000	Authorized
7031356	340100/50/24/10000420	12/10/2024 06:38	5528880	45450	Authorized

Total Authorized amount:- Rs 85450 (EIGHTY FIVE THOUSAND FOUR HUNDRED AND FIFTY)

Authorization Remarks: Claim will be settled as per agreed tariff in policy terms and condition irrespective of al amount issued.

Hospital Agreed Tariff:

I **Package Case:**
- Agreed Package Rate : NA

II **Non-package Case:**
- i. Room Rent/day : NA
- ii. ICU Rent/day : NA
- iii. Nursing Charges/day : NA
- iv. Consultant Visit Charges/day : NA
- v. Surgeon's fee/OT/Anesthetist : NA
- vi. Others (specify) : NA

Authorization Summary:

Total Bill Amount	: 85450
*Other Deductions	: 0
Discount	: 0
Co-Pay	: 0
Deductibles	: 0
Total Authorised Amount	: 85450
Amount to be paid by insured	: 0

*Other Deduction Details :

Sl.no	Description	Bill Amount	Deducted Amount	Admissible Amount	Deduction Reason

Terms and Conditions of Authorization:

1. Cashless Authorization letter 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 policyholder 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 empanelled with the hospital), Network Provider may give treatment after obtaining specific consent of policyholder.
7. Differential Costs borne by policyholder 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

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals /Chemists supported by proper prescription.
3. Diagnostic Test Reports and Receipts supported by note from the attending Medical Practitioner /Surgeon recommending such Diagnostic supported by note from the attending Medical Practitioner / Surgeon recommending such diagnostic tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner/ Surgeon giving patient's condition and advice on discharge.
6. Please submit member paid receipt copy of the difference in AL amount and Hospital bill (excluding TPA discount) at the time of claim submission.
7. Invoice of implants.
8. Radiology Films.

Name of the Product - GROUP MEDICLAIM-FLOATER and UIN No - Important Policy terms & conditions (sub-limits/co-pay deductible etc)

Please note that the amount authorized is provisional and is subject to change based on the final bill and discharge summary and deduction of TDS as applicable.

IMPORTANT POINT FOR CASHLESS PAYMENT:

1. Final Bill & Discharge summary is mandatory for validation of authorized amount. In the absence of discharge intimation or final authorization all previous AL amount will stand null & void.
2. Insurer reserve the right to demand invoice and /or sticker of high value implant & consumables or medicine at the time of settlement. Non submission may lead to denial of entire claim or deduction of such amount during final settlement or possible recovery of such amount due to non-submission of invoice.
3. Radiology films and all original investigation report to be submitted in the claim file to avoid payment delay or recovery of such amount paid erroneously on account of non-submission.
4. Hospital is requested to submit the claim file within 2 days from patient discharge date for hassle free payment.

This is a system generated letter hence signature is not required.