

Hospital Id No:

PRE-AUTHORIZATION / CLAIM FORM FOR CASHLESS FACILITY

TO BE FILLED BY THE INSURED/PATIENT

Patient Name: Kalar Selvan Health Card No. \_\_\_\_\_

Gender:  Male  Female Age: 46 (yrs) DOB: \_\_\_\_\_ Policy No: \_\_\_\_\_

Patient/Attendant Mobile No. 9840208611 Employee ID 0479429 Company Name Caterpillar

Currently do you have any other Mediclaim / Health Insurance  Yes  No (if yes, provide other insurance details)

Insurance Co. Name \_\_\_\_\_ Policy No: \_\_\_\_\_

Sum Insured \_\_\_\_\_ since how long you have this cover \_\_\_\_\_

Do you have Family Physician  Yes  No. Name of Family Physician: \_\_\_\_\_ Mobile No: \_\_\_\_\_

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

Name of the Hospital: Medway hospital City: \_\_\_\_\_

Type of hospitalization:  Emergency  Planned Expected Admission Date: 18/01/24 Time of Admission \_\_\_\_\_

Expected Length of Stay: \_\_\_\_\_ (days) Name of Treating Doctor: Dr. Palayyan Mobile No: \_\_\_\_\_

Nature of Illness / Disease with Presenting Complaints: Gp, (L.E) scrotal swelling x. 40  
M/o, slip & fall

Relevant Clinical Findings: \_\_\_\_\_

Duration of present Ailment: \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Days Date of First Consultation: \_\_\_\_\_

Past History of Present Ailment if any: \_\_\_\_\_

Provisional Diagnosis: Epididymo-orchitis / Funiculitis / Proctitis ICD Code: \_\_\_\_\_

Proposed Line of Treatment during Hospitalization:  Medical  Surgical  Intensive  Investigation  Non Allopathic treatment  
If Investigation & /or Medical Management, provide details: Enrol

Route of Drug Administration: Oral If Surgical, Name of Surgery: B/L. Hydrocelectomy

Type of Anesthesia:  Local  General  Regional  Dissociative ICD PCS Code: \_\_\_\_\_

If other treatments provide details: \_\_\_\_\_

In case of Accident / Injury:  RTA  Intentional Self Injury Date of Accident / Injury: \_\_\_\_\_

How did injury occur: \_\_\_\_\_

Injury / Diseases caused due to Substance Abuse / Alcohol Consumptions:  Yes  No

Test conducted to establish this:  Yes  No Reported to Police:  Yes  No FIR / MLC No: \_\_\_\_\_

In case of Maternity: G \_\_\_\_\_ P \_\_\_\_\_ L \_\_\_\_\_ A \_\_\_\_\_ LMP Date: \_\_\_\_\_ Date of Delivery \_\_\_\_\_

Mode of Delivery:  VD  LSCS

PAST HISTORY OF ANY CHRONIC ILLNESS WITH DURATION:

Disease / Ailment			Duration (Specify Year / Month / Days)	
	Yes	No		
Hypertension				
Hyperlipidemia				
Cancer				
Osteoarthritis				
Diabetes				
Cardiovascular Diseases				
Asthma / COPD / Bronchitis				
Any Surgery / Hospitalization				
Any Other Disease / Disability				
Congenital				
Any HIV or STD/Related Ailments				
Alcohol or Drug Abuse				

Expense Head	Amount (Rs.)	Expense Head	Amount (Rs.)
Room Rent per day + Nursing/Service charges + Diet		Investigations + Diagnostics	
ICU charges per day		Medicines / Consumables	
Doctor / Consultant visit charges		Equipment / Monitor etc	
Surgeon charges + Anesthetist		Miscellaneous (specify)	
Operation Theatre Charges		Implant Charges (if any)	
Package Charges	₹ 125,000/-		

Estimate of Expenses: Total Amount Rs. ₹ 1,25,000/- Class of Accommodation: \_\_\_\_\_

**DECLARATION**

I have completed this form and will be responsible for correctness of the medical information certified by me. I agree that Future Generali shall not be liable to make payment in case of any discrepancy between the preauthorization form and discharge summary.

Name of the treating Doctor: V. Palapoffan Qualification: MD **CHINNAI HOSPITALS**

MCI Registration No with State Code: \_\_\_\_\_

No. 2, Old No. 26, 1st Main Road,

United India Colony,

Kodambakkam, Chennai - 600 024

Signature of Doctor: [Signature] Stamp / Seal of Hospital: \_\_\_\_\_  
 BENEFICIARY CONSENT / AUTHORIZATION I have 'No Objection' to Future Generali obtaining details of my treatment / collecting documents and also hereby authorize Future Generali to pay the hospital bill from the sum insured of my insurance policy. I also undertake to pay all non medical / non authorized expenses in the hospital bill directly to the hospital at the time of discharge. In case Future Generali issues "Denial of cashless facility" to the provider, I have 'No objection' in paying the hospital bill for the treatment given. All information provided above is true and I agree that if I have provided any false or untrue information, my right to claim the expenses shall be absolutely forfeited.

NAME OF INSURED: Kalash SIGNATURE OF INSURED: [Signature]

INSURED Email ID: \_\_\_\_\_ INSURED Mobile No: \_\_\_\_\_

**Declaration by the patient/representative**

I agree to allow the hospital to submit all original documents pertaining to hospitalization to the insurer after the discharge. I agree to sign on the final bill and the discharge summary before my discharge. Payment to hospital is governed by the terms and conditions of the policy. In case the insurer is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy. All non medical expenses and expenses not relevant to current hospitalization and the amounts over and above the limit authorized by the insurer not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact insurer at the toll free no on the reverse of the form. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer. I agree and understand that insurer is in no way warranting the services of the hospital and the insurer is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other medical scheme or insurance. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer.

Patient's /Insured's Name Kalash Contact No: \_\_\_\_\_ Patient's / Insured's Signature [Signature]

**Hospital Declaration**

We have no objection to any authorized insurance company official verifying documents pertaining to hospitalization. All valid original documents duly countersigned by the insured/patient as per the check list below will be sent to insurance company within 7 days of the patient's discharge. All non medical expenses or expenses not relevant to hospitalization/illness, or expenses disallowed in the authorization letter of the insurance company, or arising out of incorrect information in the preauthorization form will be collected from the patient.

WE AGREE THAT INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY OR OTHER DOCUMENTS. The patient declaration has been signed by the patient or by his / her representative in our presence. We agree to provide clarification for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal: No. 2, Old No. 26, 1st Main Road, Doctor's Signature: \_\_\_\_\_  
CHINNAI HOSPITALS  
United India Colony,  
Kodambakkam, Chennai - 600 024

Documents to be provided by the hospital in support of the claim

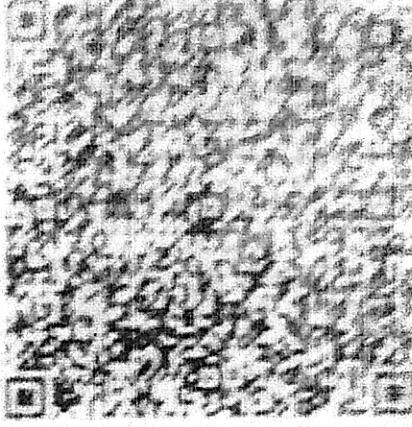
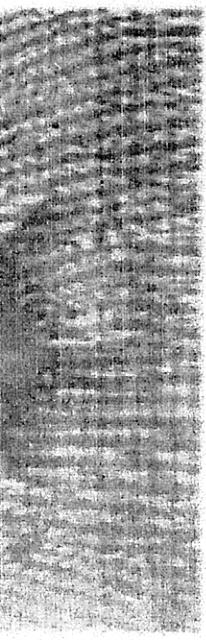
1. Authorization Letter
2. Original Detailed Discharge Summary
3. Original Hospital Main Bill and Detailed Break Up
4. All Original Pharmacy Bills and Investigation Bill if any
5. All Investigation Reports & Prescriptions Including OT Notes

பெயர் (பெண்/மென்றை)

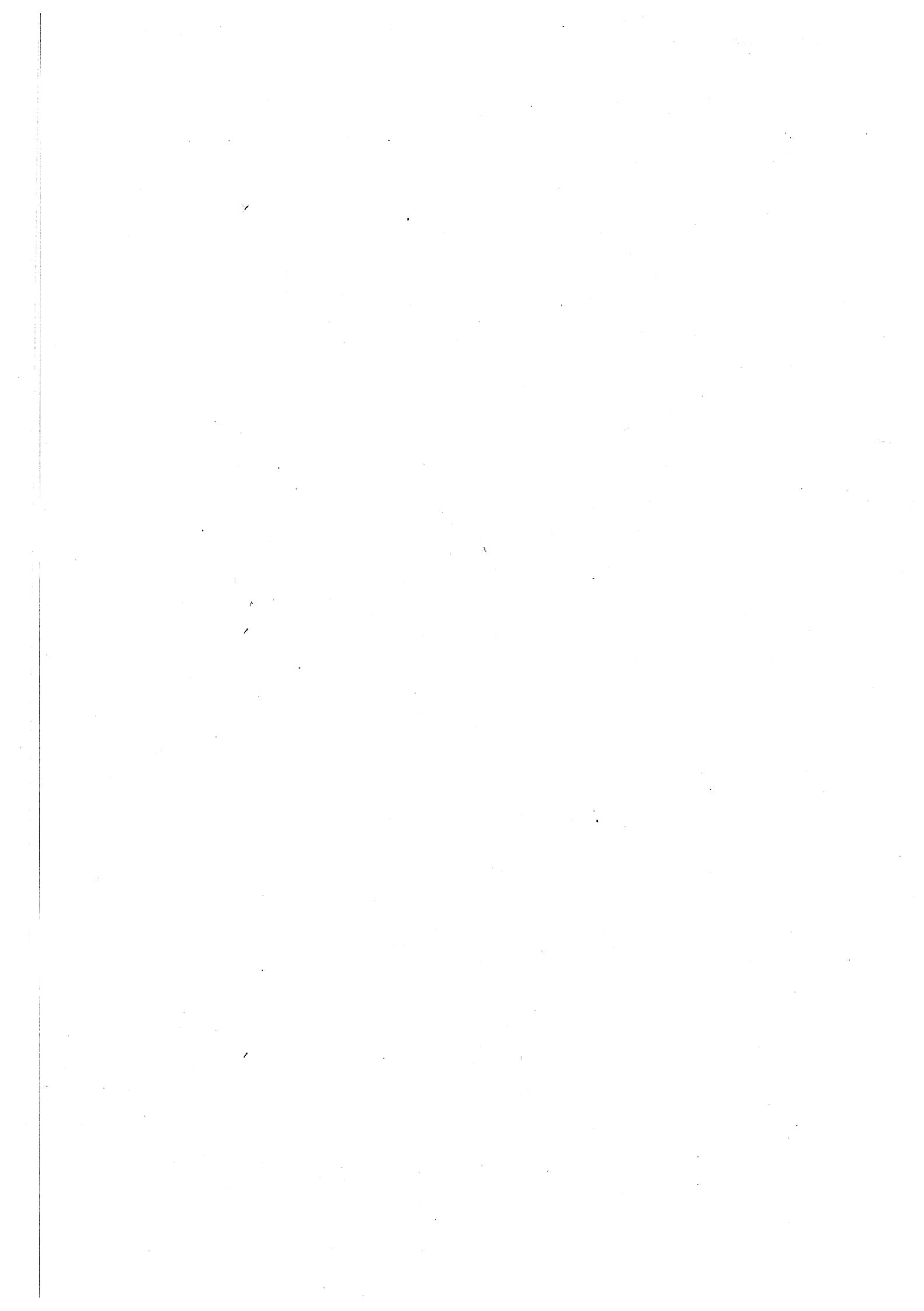
M Kalaiselvan

உயிர் பிறை / DOB: 09/09/1977

ஈடு / MALE



30007 0243



போகும்பி:

S/O முருகன், 3/24, மாஷீ  
கோட்டை, திருவால்லூர்,  
திருவால்லூர் - 600116

Address:

S/O Murugan, 3/24, MOSQUE  
STREET, JAYA NAGAR, PONNU-  
KALI, திருவால்லூர்,  
திருவால்லூர் - 600116

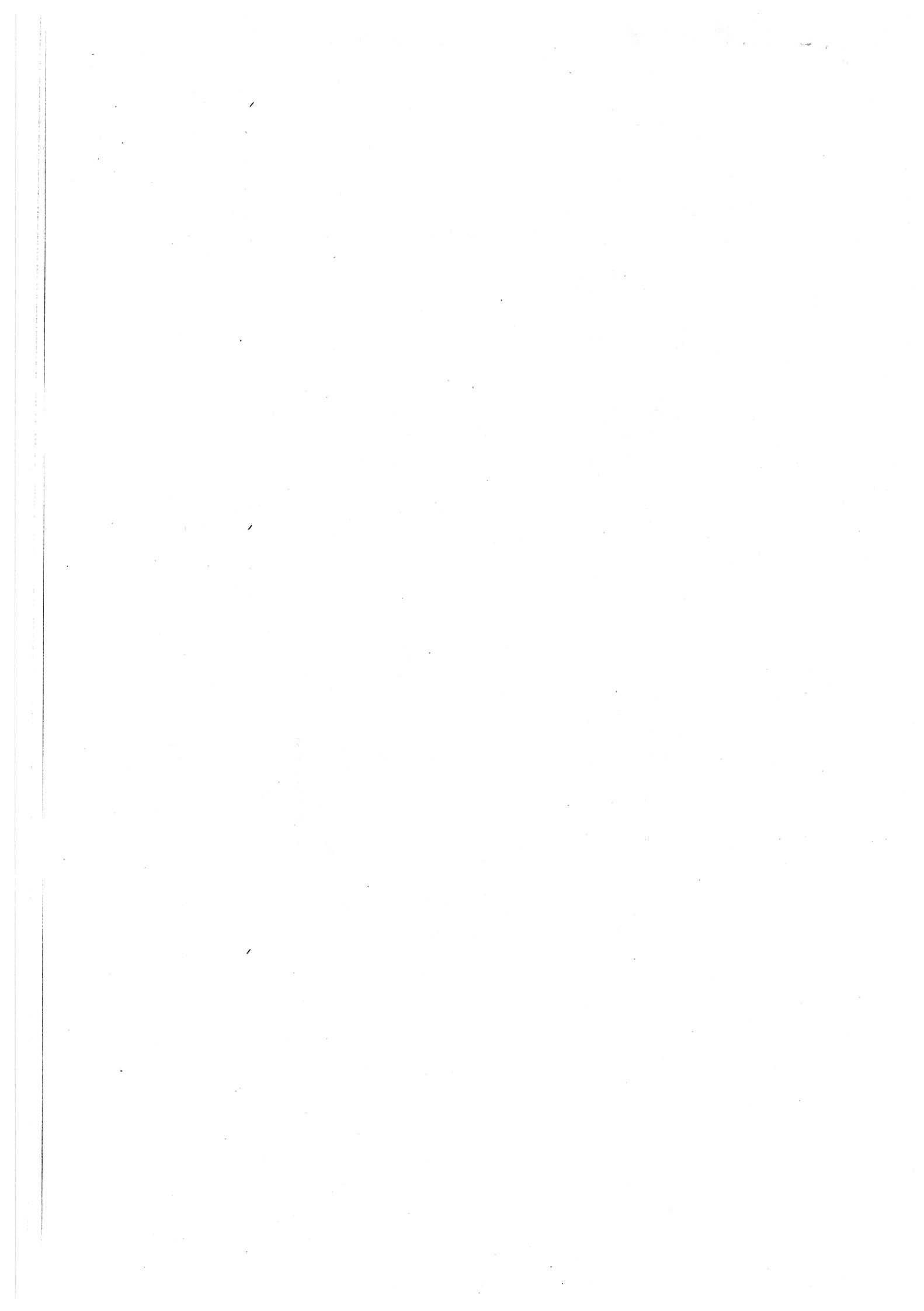
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H. K. S. J. L. M

Emergency Contact No : 9094609370  
Permanent Address : 3/24 Mosque Street  
Jayanagar P O,  Chennai-600116  
Present Address : 3/24 Mosque Street  
Jayanagar P O,  Chennai-600116  
Date of Birth : 09.09.1977  
S/o. Murugan  
Kalaivelan  
Permanent Address : 3/24 Mosque Street  
Jayanagar P O,  Chennai-600116  
Present Address : 3/24 Mosque Street  
Jayanagar P O,  Chennai-600116  
Chennai-600116  
3/24 Mosque Street  
Jayanagar P O,  Chennai-600116  
Date of Issue : 01.12.2017  
Blood Group : O+ve  
Nature of Employment : Permanent

Registration No. TWR 53) Ph. +91 41 3996 9000  
Methandalam, Thiruvalluvar - 602 002, Tamilnadu, India  
Caterpillar India Pvt. Ltd.

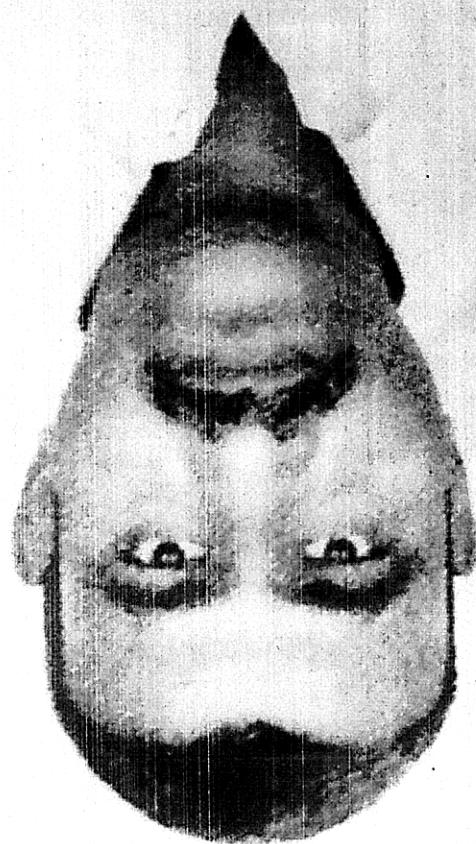


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MURUGAN

KALASELVAN







# AMBUJAM SCANS AND LAB

*Sincere Scanning*

Dr. M.RAJESH KUMAR M.B.B.S., DMRD.,

Name : Mr. KALAISELVAN.M

Date: 03.12.2023

Age : 47 Y/M

Id.No: 00285

Ref. By.: Dr. N. RAJALAKSHMI, B.H.M.S.,

UHID: 00662

## DOPPLER ULTRASONOGRAPHY OF SCROTUM

### Right Testis:

Normal size measures 4.2 x 2.5 x 1.9 cms.

The echotexture normal. No focal lesion noted. Normal vascularity noted.

Right epididymis appear normal in size and echotexture.

No evidence of hydrocele.

**Right spermatic cord appear prominent and echogenic with increased vascularity within it.**

### Left Testis:

Normal size measures 4.3 x 2.5 x 2.1 cms.

The echotexture normal. No focal lesion noted. Normal vascularity noted.

0.3 x 0.3 cm size small simple cyst seen in head of left epididymis.

Left epididymis appear mildly prominent with altered echotexture and shows mild increased vascularity within it.

Left spermatic cord appear echogenic and prominent with increased vascularity within it.

6.8 x 4.3 cm size large fluid collection with floating internal echoes within it seen in left scrotal sac.

No significant varicocele noted on both sides.

### **PORUR BRANCH**

YOGANARASIMAR TOWERS, No.61/100, Mount Poonamalle Road,  
(Near - Narayana Pearls), Porur, Chennai - 600116.  
Contact No: 044 24828582, 87544 50876/73580 55878,  
ambujamscans@gmail.com

### **KUNDRATHUR BRANCH**

1st Floor, Brindavan Apartments, No.47-A, Porur Kundrathur Main Road  
(Near - Parimalam Theatre), Kundrathur, Chennai - 600069.  
Contact No: 73059 71764/ 73059 76603 / 73580 55878



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Name : Mr. KALAISELVAN.M

Date: 03.12.2023

Age : 47 Y/M

Id.No: 00285

Ref. By.: Dr. N. RAJALAKSHMI, B.H.M.S.,

UHID: 00662

## DOPPLER ULTRASONOGRAPHY OF SCROTUM

### IMPRESSION:

- Moderate Left Hydrocele.
- Left epididymis appear mildly prominent with altered echotexture and shows mild increased vascularity within it. Left Spermatic Cord appear echogenic and prominent with increased vascularity within it.
  - s/o Left Epididymitis and Left Funiculitis.
- Right Spermatic Cord appear prominent and echogenic with increased vascularity within it.
  - s/o Right Funiculitis.
- Small left epididymal cyst. (insignificant)
- Normal Study of Bilateral Testes and Right Epididymis .

  
Dr. M. Rajesh Kumar. MBBS., DMRD  
Consultant Radiologist.,  
Reg No : 75842

### **PORUR BRANCH**

SRI YOGANARASIMAR TOWERS, No.61/100, Mount Poonamalle Road,  
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(Near - Parimalam Theatre), Kundrathur, Chennai - 600069.  
Contact No: 73059 71764/ 73059 76603 / 73580 55878

**DRUG CHART**

MHI PRINT

(200)

Name of the Patient : M.Y. Valsalvano Age: 16y Sex: M Bed No. 0201

Clinical Diagnosis : IP No..... Ht..... Wt.....

PID No. 2010

Primary Consultant Name : Dr. T. Palaniswami

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