FUTURE GENERALI
TOTALLY UNLIMITED SOLUTIONS

Phone: 1800 209 1016 / 1800 103 8889
Fax: 1800 209 1017 / 1800 103 9998
Email: fgh.cashless@futuregenerali.in

FUTURE GENERALI Health

Hospital Id No: FGH-PAF-03

PRE-AUTHORIZATION / CLAIM FORM FOR CASHLESS FACILITY

TO BE FILLED BY THE INSURED/PATIENT

Patient Name: Kalai Selvan. Health Card No.

Gender: ☑ Male ☐ Female Age: 46 (yrs) DOB: Policy No:

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

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. palaiappan Mobile No:

Nature of Illness / Disease with Presenting Complaints: C/o, (LE) Scrotal swelling x. c/o H/o, slip & fall.

Relevant Clinical Findings:

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

Past History of Present Ailment if any - Nil -

Provisional Diagnosis: Epididymoorchitis / Funicalitis / Hydrocele ICD Code:

Proposed Line of Treatment during Hospitalization: ☐ Medical ☑ Surgical ☐ Intensive ☐ Investigation ☐ Non Allopathic treatment

If Investigation & /or Medical Management, provide details: Enclosed

Route of Drug Administration: I/V/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: N/A

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)
Hypertension	Yes		No		
Hyperlipidemia	Yes		No		
Cancer	Yes		No		
Osteoarthritis	Yes		No		
Diabetes	Yes		No		
Cardiovascular Diseases	Yes		No		N/.
Asthma / COPD / Bronchitis	Yes		No		
Any Surgery / Hospitalization	Yes		No		
Any Other Disease / Disability	Yes		No		
Congenital	Yes		No		Internal / External
Any HIV or STD/Related Ailments	Yes		No		
Alcohol or Drug Abuse	Yes		No		

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

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FUTURE GENERALI Health

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	₹1,25,000/-		

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: N. Balasubramanian Qualification: _____

MCI Registration No with State Code: _____

Signature of Doctor: _____ Stamp / Seal of Hospital

GANGWAY HOSPITALS
No. 2, Old No. 26, 1st Main Road,
United India Colony,
Kodambakkam, Chennai-600 024

BENEFICIARY CONSENT / AUTHORISATION **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: Kalavathi SIGNATURE OF INSURED: _____

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 it 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 Kalavathi **Contact No:** _____ **Patient's / Insured's Signature** _____

Hospital Declaration

We have no objection to any authorized insurance company official verifying documents pertaining to hospitalization. All valid original documents duly counter singed 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: GANGWAY HOSPITALS
No. 2, Old No. 26, 1st Main Road,
United India Colony,
Kodambakkam, Chennai-600 024. **Doctor's Signature:** _____

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**

மு. கலைசெல்வன்

M Kalaiselvan

பிறந்த நாள்/ DOB: 09/09/1977

ஆண் / MALE

3008 7309 9243

முகவரி:

S/O முருகன், 3/24, மசூதி
தெரு, ஜெயா நகர், போரூர்,
திருவள்ளூர்,
தமிழ் நாடு - 600116

Address:

S/O Murugan, 3/24, MOSQUE
STREET, JAYA NAGAR, Porur,
Tiruvallur,
Tamil Nadu - 600116

3008 7309 9243

Caterpillar India Pvt. Ltd.

Mahallathur Thiruvallur - 602 002. Tamilnadu India
(Register No TVR 53) Ph : +91 44 3996 9000

Kalaiselvan

S/o. Murugan

Date of Birth : 09.09.1977

Permanent Address:
3/24 Mosque Street
Jayanagar Porur,
Chennai-600116

☎ 9840208611

Present Address :
3/24 Mosque Street
Jayanagar Porur,
Chennai-600116

Emergency Contact No : 9094609370

Nature of Employment : Permanent

Blood Group : O+ve

Date of Issue : 01.12.2017

K. Kalaiselvan

Signature of the Holder

Issuing Authority

KALAISELVAN
MURUGAN
0479429

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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,
r - Narayana Pearls), Porur, Chennai - 600116.
t No: 044 24828582, 87544 50876/73580 55878,
ambujamscans@gmail.com

KUNDRATHUR BRANCH

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

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

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,
Near - Narayana Pearls), Porur, Chennai - 600116.
Contact No: 044 24828582, 87544 50876/73580 55878,
mail id : ambujamscans@gmail.com

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(Near - Parimalam Theatre), Kundrathur, Chennai - 600069.
Contact No: 73059 71764/ 73059 76603 / 73580 55878

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DRUG CHART

Name of the Patient : Mr. Kalaiselvan Age 46y Sex M Bed No. 2(A)

Clinical Diagnosis : IP No. 0187 Ht. Wt.

Primary Consultant Name : DR. T. Palaniappan PID No. 3070

Name of the Medicine	Dose	Route	Frequency	18/1/24	19/1/24
Inj Cefol-S	1.5gm	IV	1-0-1	5:30 PM	9 AM
Inj Tuscool	40mg	IV	1-0-1	5:30 PM	9 AM
Inj Glutabliss	1amp	IV	STAT	5:30 PM	10 AM
TAB. OLMY AH	40/5mg	P/O	1-0-0		

Administered by (Nurse Signature) : [signature] [signature]

Verified by (DMO Signature) : [signature] [signature]

Nurse Signature : [signature]
Nurse Name : [signature]
Date & Time : 18/1/24 @ 4PM

DMO Signature : [signature] 18/1/24
DMO Name : Peer Mohamed Farhan
Date & Time : 18/1/24 @ 5:10pm

Primary Consultant Signature : [signature]
Primary Consultant Name : DR. T. Palaniappan
Date & Time : 18/1/24 @ 4PM
Reg No. : 55530

Adverse Reaction, if any ....