REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART - C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL

a. Name of TPA / Insurance company: **VIDAL HEALTH INSURANCE TPA PRIVATE LTD.**

b. Toll free phone number:

c. Toll free fax:

d. Name of Hospital: **MEDWAY HOSPITALS**

i. Address **# 2/26, 1st MAIN ROAD, UNITED INDIA COLONY, KODAMBAKKAM, CHE-600024**

ii. Rohini id **8900080347533**

iii. e-mail id **MEDWAYINSURANCE@GMAIL.COM**

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : Pushpalatha

B. Gender: ☐ Male ☑ Female ☐ Third Gender

C. Age: 61. (Years) / (Month)

D. Date of Birth: (DD/MM/YYYY)

E. Contact number: 9952965880

F. Contact number of attending Relative:

G. Insured Card ID number: CHE-RJ-52214-001-0000236-E

H. Policy number / Name of Corporate:

I. Employee ID:

J. Currently do you have any other mediclaim / health insurance: ☐ Yes ☑ No

i. Company Name:

ii. Give Details

K. Do you have a family Physician: ☐ Yes ☑ No

L. Name of the Family Physician: NA

M. Contact number, if any:

N. Current Address of Insured patient:

O. Occupation of Insured patient:

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor: Dr. Palaniappan

B. Contact number: 044-24734455

C. Nature of Illness / Disease with presenting complaint: C/O, fever, Burning micturition,

D. Relevant Critical Findings: Painful micturition, lower Abdominal pain

E. Duration of the present ailment: 5 Days

i. Date of First consultation: 17/01/2024 (DD/MM/YYYY)

ii. Past history of present ailment, if any Nil

F. Provisional diagnosis: B/L. Renal calculus.

i. ICD 10 code Nil

G. Proposed line of treatment:

i. Medical Management ( )
ii. Surgical Management ✓
ii. Intensive care ( )
iv. Investigation ( )
v. Non-allopathic treatment ( )

H. If investigation and / or Medical Management, provide details Enclosed

i. Route of Drug Administration : Oral

I. If surgical, name of surgery ~~URS~~ URS & B/L, stenting.

i. ICD I0 PCS code - Nil -

J. If other treatment, provide details -

K. How did injury occur -

L. In case of accident

i. Is it RTA: ☐ Yes ☐ No
ii. Date of Injury: NA (DD/MM/YYYY)
iii. Report to Police ☐ Yes ☐ No
iv. FIR NO:
v. Injury / Disease caused due to substance abuse / alcohol consumption ☐ Yes ☐ No
vi. Test conducted to establish this (if yes, attach report) ☐ Yes ☐ No

M. In case of Maternity ☐ G ☐ P ☐ L ☐ A

i. expected date of Delivery (DD/MM/YYYY) NA

DETAILS OF PATIENT ADMITTED

A.	Date of admission	17/01/24. (DD/MM/YYYY)
B.	Time of admission	(HH:MM)
C.	Is this an emergency / planned hospitalization event:	Emergency ☑ Planned ☐
D.	Mandatory Past History of any chronic illness	if yes (since __ /____)(month/year)
	i. Diabetes	/
	ii. Heart disease	/
	iii. Hypertension	/
	iv. Hyperlipidemias	/
	v. Osteoarthritis	/
	vi. Asthma/COPD/Bronchitis	/ Nil
	vii. Cancer	/
	viii. Alcohol/Drug abuse	/
	iX. Any HIV/ or STD Related ailment	/
	X.Any other ailment, give details	
E.	Expected number of Days / stay in hospital	4-5 Days
F.	Days in ICU	Days
G.	Room Type	Pvt
H.	Per day room rent+nursing and service charges+ patients diet	
I.	Expected cost of investigation + diagnostic	
J.	ICU charges	
K.	OT charges	
L.	Professional fees Surgeon + Anesthetist Fees + consultation Charges	
M.	Medicines + Consumables + Cost of Implants (if applicable please specify)	
N.	Other hospital expenses if any	
O.	All-inclusive package charges if any applicable	
P.	Sum Total expected cost of hospitalization	₹ 1,80,000/-

DECLARATION
(Please read very carefully)

We confirm having read understood and agreed to the Declarations of this form

a. Name of the treating doctor — Dr. Palaniappan

b. Qualification:

c. Registration number with State code

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

Hospital Seal
(Must include Hospital ID)

Patient / Insured Name and Sign

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer / TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

c. All non-medical expenses and expenses not relevant to current hospitalization and the amount over & above the limit authorized by the Insurer / T.P.A. not governed by the terms and conditions of the policy will be paid by me.

d. I hereby declare to abide by the terms and conditions of the policy and if at any facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / T.P.A.

e. I agree and understand that T.P.A. is in no way warranting the service of the hospital & that the Insurer / TPA is no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, Suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer / TPA.

h. "I/We authorize Insurance Company / TPA to contact me/us through mobile/email for any update on this claim"

a) Patient's / Insured's Name: _____

b) Contact Number: _____ email-Id (optional) _____

c) Patient's / Insured's Signature: _____

Date: _____ Time: _____

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.

c. We agree that TPA / 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.

d. The patient declaration has been signed by the patient or by his representative in our presence.

e We agree to provide clarifications for the queries raised regarding this hospitalization and we take responsibility the sole for any delay in offering clarifications.

f. We will abide by the terms and conditions agreed in the MOU.

g. We confirm that no additional amount would be collected from the insured 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).

h. We confirm that no recoveries would be made 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).

i . 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 from us (the Network Provider) and / or take necessary action , as provided under the MoU or applicable laws.

Hospital Seal

[illegible] HOSPITALS
No. 2, Cid No. 26, 1st Main Road.
United India Colony,
[illegible]ai-600 024

Doctor's Signature

Date: _____ Time: _____

Royal Sundaram
General Insurance

VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR

Card No : CHE-RS-S2214-001-0000236-E
PUSHPALATHA G
Sex : F **Age :** 61 Year/s

SUNDARAM CLAYTON LIMITED
Valid From : 28-Jun-2023
Emp No : 506649

This card is non-transferable. It is used only for identification purposes and not as an authorisation to proceed with the treatment or as any guarantee for payment. Use of this card is governed by the policy terms & conditions. This card is valid at hospitals empanelled with Vidal Health Insurance TPA Private Limited. Cashless hospitalisation can be availed of but it is subject to preauthorisation approval by Vidal Health. In case preauthorisation is not approved, the policy holder is required to make payment to the hospital and submit the claims to Vidal Health for a possible reimbursement. For hospitalisation bills pertaining to non medical expenses, the policy holder is required to make payment to the hospital directly. This card is to be produced with Pan Card/Passport/Driver's License/Voter's ID card to prove identity of the claimant. This card is valid subject to continued renewal of the policy. Vidal Health Insurance TPA Private Limited is your authorised Third Party Administrator.

For an updated hospital list with local contact details please visit: **www.vidalhealthtpa.com**

VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR

Bengaluru: 080-40125600, **Bhubaneswar:** 0674-2530392, **Chennai:** 044-42094444
Coimbatore: 0422-2491335, **Delhi:** 011-23715781, **Hyderabad:** 040-66061300-01
Kochi: 0484-2358683, **Kolkata:** 033-22884196, **Mumbai:** 022-23214700
Pune: 020-25530398, **Vizag:** 0891-6670197

If found please return to:
Vidal Health Insurance TPA Private Limited
Tower No. 2, First Floor, SJR I Park, EPIP Zone, Whitefield, Bangalore-560 066.
E-mail: help@vidalhealthtpa.com **Website:** www.vidalhealthtpa.com

இந்திய அரசாங்கம்

Government of India

புஷ்பலதா

Pushpalatha

பிறந்த நாள்/DOB: 06/10/1962

பெண்பால் / Female

2691 6347 7843

ஆதார் - சாதாரண மனிதனின் அதிகாரம்

இந்திய தனித்துவ அடையாள ஆணையம்

Unique Identification Authority of India

ஆதார்

முகவரி: W/O: கோபாலகிருஷ்ணன்
31/177
13வது கிழக்கு குறுக்குத் தெரு
மகாகவி பாரதி நகர், வியாசர்பாடி
வியாசர்பாடி, சென்னை, தமிழ் நாடு
600039

Address: W/O:
Gopalakrishnan, 31/177,
13TH EAST CROSS
STREET, MAHAKAVI
BHARATHI NAGAR,
Vyasarpadi, Vyasarpadi,
Chennai, Tamil Nadu,
600039

2691 6347 7843

1947
1800 300 1947

help@uidai.gov.in

www.uidai.gov.in

आयकर विभाग

INCOME TAX DEPARTMENT

भारत सरकार

GOVT. OF INDIA

KUMAR G

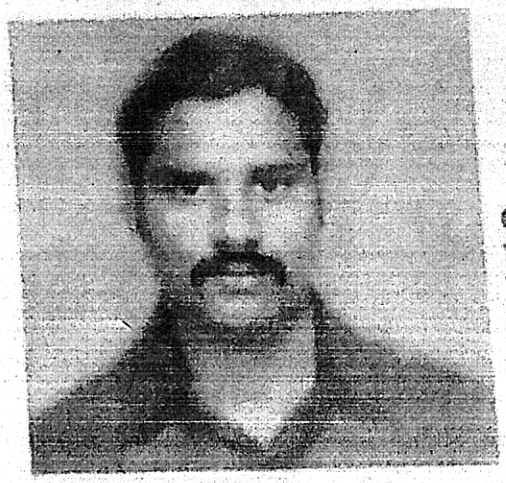
GOPALAKRISHNAN

05/04/1986

Permanent Account Number

BVSPK5375C

Signature



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இந்திய அரசாங்கம்

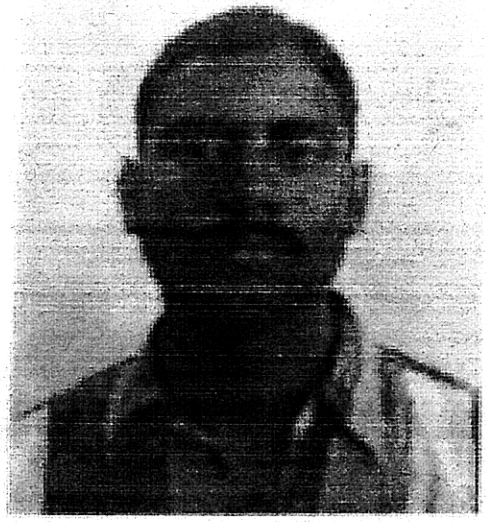
Government of India

குமார்

Kumar

பிறந்த நாள் / DOB : 05/04/1986

ஆண்பால் / Male



2611 7425 1116

ஆதார் - சாதாரண மனிதனின் அதிகாரம்

Unique Identification Authority of India

முகவரி
S/O: கோபாலகிருஷ்ணன், 31/177,
13வது கிழக்கு குறுக்குத் தெரு,
மகாகவி பாரதி நகர்,
வியாசர்பாடி, வியாசர்பாடி,
சென்னை, சென்னை, தமிழ்
நாடு, 600039

Address
S/O: Gopalakrishnan, 31/177,
13TH EAST CROSS STREET,
MAHAKAVI BHARATHI NAGAR,
Vyasarpadi, Vyasarpadi, Chennai,
Chennai, Tamil Nadu, 600039

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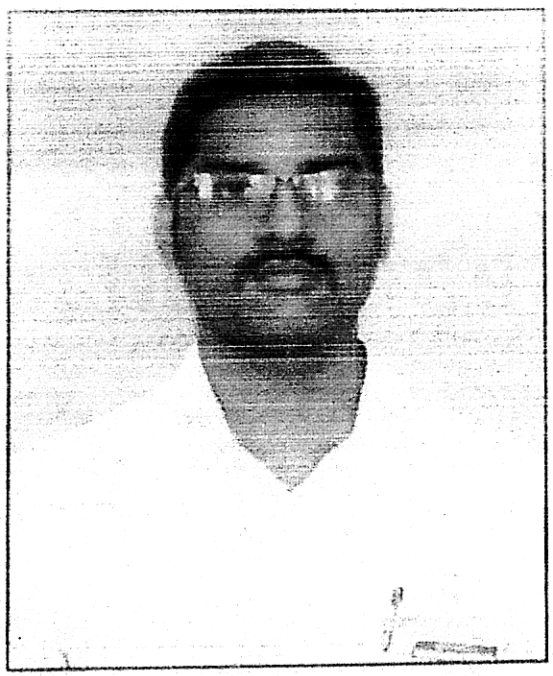

Name :KUMAR G

Emp. No.:506649

Employee's Signature

Authorised Signatory

Sundaram - Clayton Limited

MTH Road, Padi, Chennai - 600 050.

Reg No.: TVR 759, Tel: 26258212, 26135000

PATIENT NAME:	MRS.PUSHPA LATHA	AGE/GENDER :	61YRS/FEMALE
PATIENT ID :	MMH-202473059	DATE :	17.01.2024
REFD DR :	DR.T.PALANIAPPAN	MODALITY :	CT
		ACC NO :	CT-2448

CT WHOLE ABDOMEN PALIN REPORT

LIVER: Normal in size with normal density noted. The porta hepatis is normal. The intrahepatic portal venous radicals are normal. No evidence of intrahepatic billiary radicular dilatation. The hepatic veins and intrahepatic portion of inferior venacava are normal.

GALL BLADDER: Normal in size, shape and outlines. Peri-cholecystic area is normal. The common bile duct is not dilated.

SPLEEN: Normal in size, shape and attenuation values. The splenic hilum and splenic vein are normal.

PANCREAS: Normal in size, contour and attenuations values. No evidence of focal mass lesion/pancreatic duct dilatation.

Adrenal glands: Normal in size, shape and attenuations values.

KIDNEYS:

Right kidney: Right mild hydroureteronephrosis noted. Radiodense calculus of size approximately 13 mm noted in the proximal ureter .

Small microlith noted in the lower pole calyx of right kidney.

Left kidney :Appears bulky with mild perinephric fat stranding. Radiodense calculus of size 3 mm noted in the lower pole calyx. Moderate hydroureteronephrosis noted. Radiodense calculi of size approximately 8 mm mm noted in the distal ureter just proximal to the vesicoureteric junction.

MH/PRINT /0054/ NRS

Medway Hospitals®

The way to better health

HISTORY & PHYSICAL EXAMINATION FORM

Mrs.PUSHPALATHA
61/Female/MH202473059
17/01/2024/IP2024000119
Dr.T.PALANIAPPAN

Patient's Name		I.P. No. :	
Age :	/ F	Ward :	Room No. : Dcu.
Consultant Dr. :		D.O.P. :	

Temp : 98.4 Pulse : 78 b. Resp : 20 b.
B/P : 130/90. Height : ± 150 cm Weight : ± 45 kg

Allergies : Not known
Current Medications : —

Pain scale: 0 No Pain; 1 Just noticeable; 2 Mild Pain; 3 Uncomfortable Pain; 4 Annoying Pain; 5 Moderate Pain; 6 Just bearable; 7 Strong Pain; 8 Severe Pain; 9 Horrible Pain; 10 Worst Pain

Complaints

Fever on and off
Abdominal & flank pain on and off } × 5 days
Burning micturition

No vomiting / breathlessness / cough / cold

History of Present illness

Minimal nausea / lack of appetite × 5 days
No issues passing urine

Past family and Personal history of relevance

K/c/o DM / HTN / hypothyroidism
Previous h/o kidney stones 10 years ago

Clinical Examination

CVS – S1S2
RS – NVBS
Abd – (L) flank pain
CNS – NFND

ABG – 7.516 / 37.7 / 52 / 30.5 ? mixed disorder

Continuation on the reverse side ☐

Investigation required

CBC / RFT / LFT / PCT

SERUM / COAGULATION

CT ABDOMEN

URINE ROUTINE + CULTURE

Diagnosis

RENAL CALCULI / B/L PELVIC + PERI URETERAL

DM / HTN / HYPERTHYROIDISM

Plan of Care

DR. GUPTA'S OPINION FOR STENTING

CYSTOSCOPY

FOLLOW VITALS + INFORM

NBM IN MORNING

INF RDS

CARDIAC CATHERISATION + ECHO

Signature

Date : .....Time : .....

Examined by

Medway Hospitals®
The way to better he[alth]

DRUG CHART

MH/ PR

Mrs.PUSHPA .ATHA
61/Female/MH H202473059
17/01/2024/II 2024000119
Dr.T.PALANIAPPAN

Name of the Patient : .... Age............... Sex............... Bed No. ....

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

Primary Consultant Name : ....PID No. ....

Name of the Medicine	Dose	Route	Frequency	17/1/24	18/1/24	19/1/24				
INJ. CEFOL - S	1.5gm	IV	1-0-1		8 AM (P2) 8 PM	8 AM (P3) 8 PM				
INJ. RAMNC	50mg	IV	1-0-1	8 PM	8 AM 8 PM	8 AM 8 PM				
Tab. AMLONG	2.5mg	PO	1-0-1		12 PM	8 AM 8 PM				
Tab. NEPHROSAVE	1 Tab	PO	1-0-1		8 PM	8 AM 8 PM				
Syp. KCl	15ml	PO	1-1-1-1			8 AM 12 PM 8 AM 8 PM	12 PM			
Syp. DUPHALAC	15ml	PO	0-0-1			8 PM				
CAP. BECASULES	1 Cap	PO	0-1-0			12 PM				
Administered by (Nurse Signature) :				[signature]	[signature]	[signature]				
Verified by (DMO Signature) :					[signature]					

Nurse Signature : [signature]	**DMO Signature :** [signature]	**Primary Consultant Signature :** [signature]
Nurse Name : S/N K. VIJAYAN 2BCT.	**DMO Name** : 17/01/24@10:00PM.	**Primary Consultant Name** : DR. T. PALANIAPPAN
Date & Time : 17/01/24@10:00PM.	**Date & Time** : 17/01/24@10:00PM.	**Date & Time** : 17/1/24@10:00PM.
		Reg No. : 55530)

Medway Hospitals
The way to better health

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS				
17/1/24	10.30 pm.	Inj Cefoloz	3g	Iv.	Dr Anish.	Ane 3119.				
18/1/24	10.80 AM	Inj: potassium	10 ml	IV	Dr. Kruthika	[illegible]				
19/1/24	11.30 Am.	Inj KCL [illegible]	10 ml	Infu.. 10 ml hours. IV	Dr. Kiruthika.	Ane 9119.				

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS				