

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

g) Per Day Room Rent + Nursing & Service charges + Patient's Diet:

Rs.

h) Expected cost for investigation + diagnostics:

Rs.

i) ICU Charges:

Rs.

j) OT Charges:

Rs.

k) Professional fees Surgeon + Anesthetist fees + Consultation charges:

Rs.

l) Medicines + Consumables cost of Implants: (specify if applicable)

Rs.

m) Other hospital expenses if any:

Rs.

n) All inclusive package charges if any applicable:

Rs.

o) Sum Total expected cost of hospitalization

Rs.

p. Mandatory past history of any chronic illness. If yes (since month/year)

- ☐ 1. Diabetes
- ☐ 2. Heart Disease
- ☐ 3. Hypertension
- ☐ 4. Hyperlipidemias
- ☐ 5. Osteoarthritis
- ☐ 6. Asthma/ COPD / Bronchitis
- ☐ 7. Cancer
- ☐ 8. Alcohol or drug abuse
- ☐ 9. Any HIV or STD / related ailments
- ☐ 10. Any other ailment give details:

DECLARATION (PLEASE READ VERY CAREFULLY)

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

a) Name of the treating doctor:

b) Qualification:

c) Registration No. with State code:

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 amounts over & above the limit authorized by the Insurer/TPA 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 time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / TPA.
- e. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in 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:

c) Email ID: (Optional)

d) 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 the sole responsibility 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.

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. Receipts and Pathological Test Reports from Pathologists, Supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of Operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

Hospital seal:

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

Doctor's signature:

Date:

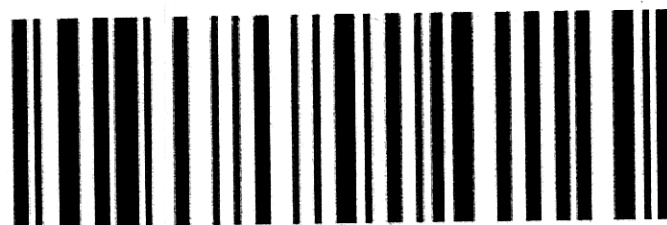
Time:



The New India Assurance Co. Ltd.

11/11/24

Lalitha Av



Beneficiary name

Lalitha Av

Member ID

5111112442

Employee code

2000096226

Relation

Mother-in-law

Date of Birth

19-Sep-1952

Primary insured

Janaki Deepa
Nagarajan

Valid upto

13-Aug-2024

Policy Holder

Hexaware
Technologies Limited

Insurer ID

MEMBER28940



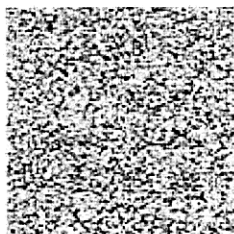
संस्कृत-साम्प्रदायिक
Government of India

Unique Identification Authority of India

Up@GauL@ start/ Enrolment No.: 0000/00771/89440

To
 Sri. K. S. S. S.
 K. S. S. S.
 D. D. Nagarajan
 Plot No. 5
 T. R. Main Road
 Thirupakkam
 Seralathur Colony
 Opp. to Thirupakkam
 Chennai - Tamil Nadu - 600097
 6001817734

Figure 1. A schematic diagram of the experimental setup. The subject is seated in a chair, viewing a screen. The screen displays a target (a red dot) and a starting point (a black dot). The subject's hand is positioned at the starting point. The distance between the starting point and the target is labeled as 'Distance'. The subject is instructed to move their hand from the starting point to the target.



உங்கள் அடையாள எண் / Your Aadhaar No. :

2408 6739 8129

VID : 9143 1011 9609 9205

சென்னை, 14.05.2014



Government of India



Janaki Deepa
DOB: 15/05/1988
GENDER: FEMALE

2408 6739 8129

VID : 9143 1011 9609 9205

எனது அ.தரம் எனது அடை யாளம்



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A674532

4. *Chlorophyll a*

- [illegible]

INFORMATION

- Aadhaar is a proof of identity, not of citizenship
- Verify identity using Secure QR Code/Offline X.M. / Online Authentication
- This is electronically generated letter

- கனடா நாடு அழைக்கிறது அமெரிக்கா, 1982
- லேபேரே: ஐக்கியத்தின் ஐக்கியமான பிரேமாவைப்
பரிக்ஷிப்போ கனடா, உதவிக்கிறது
- உலகம் பிரேமாவை, 1982 அழைக்கிறது அமெரிக்கா, 1982
உதவிக்கிறது
- அமெரிக்கா பிரேமாவை அழைக்கிறது அமெரிக்கா, 1982
உதவிக்கிறது

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Unique Identification Authority of India

முதலாம் திரு:

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-29-01 BY SP-6 BTJ/KSP

Address:

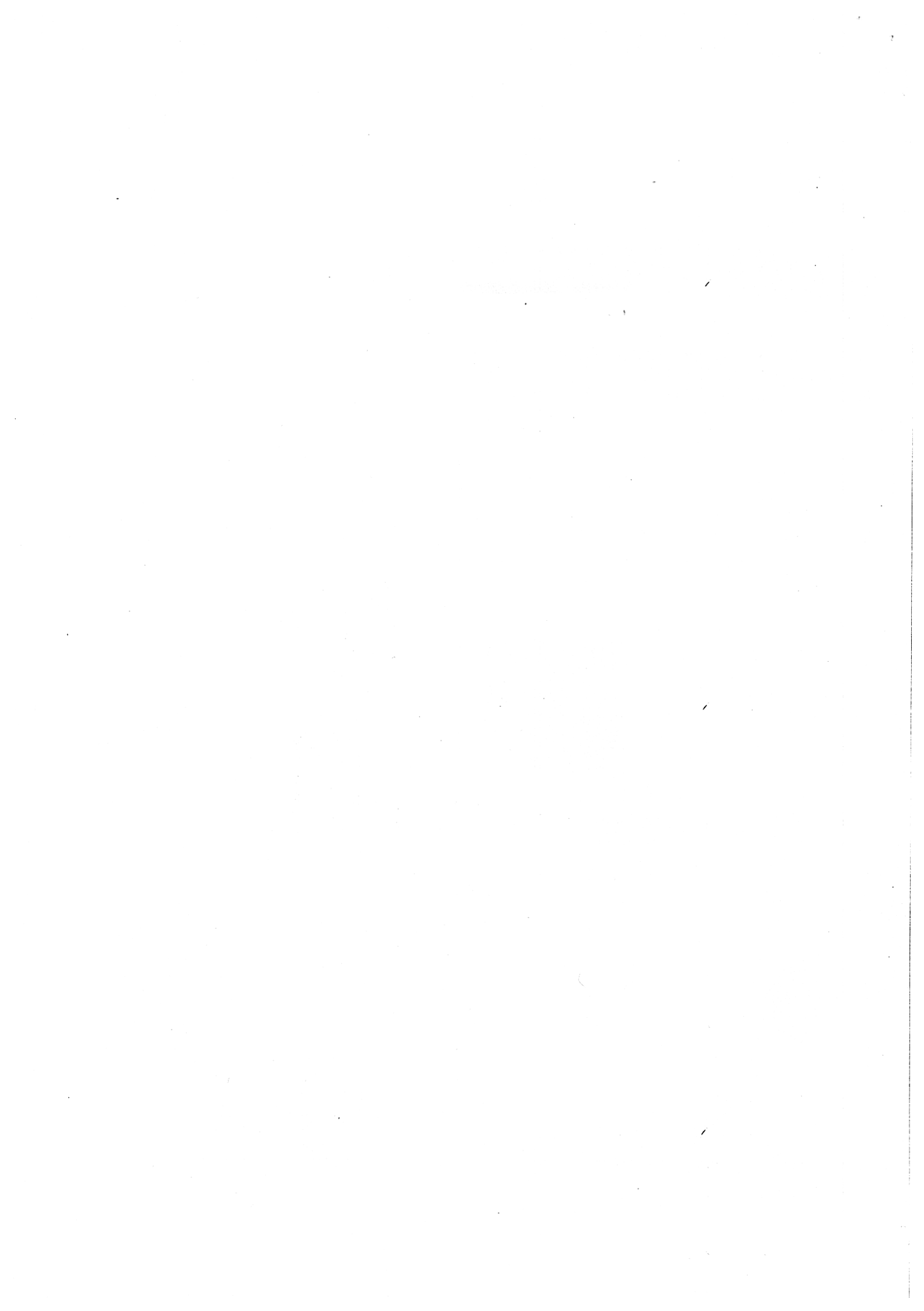
D/O Nagerajan, Plot No 5, Third Main Road,
Thuraiyakkam, Secretariate Colony, Oggim
Thuraiyakkam, Chennai,
Tamil Nadu - 600097



2408 6739 8129

VID : 9143 1011 9609 9205

1997-1998 | **THE 25TH ANNUAL SURVEY OF THE FUTURE OF THE U.S. ECONOMY** | 11



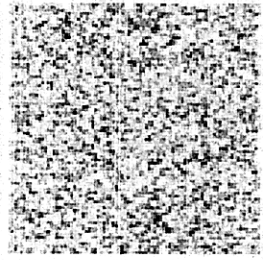
आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT OF INDIA



संयुक्त आयकर खाता
Permanent Account Number Card
ANXPJ8726A

पति / Spouse
JANAKI DEEPA
पति / HUSBAND
NAGARAJAN

जन्म तिथि / Date of Birth
15/06/1988



[Signature]
व्यक्ति / Signature

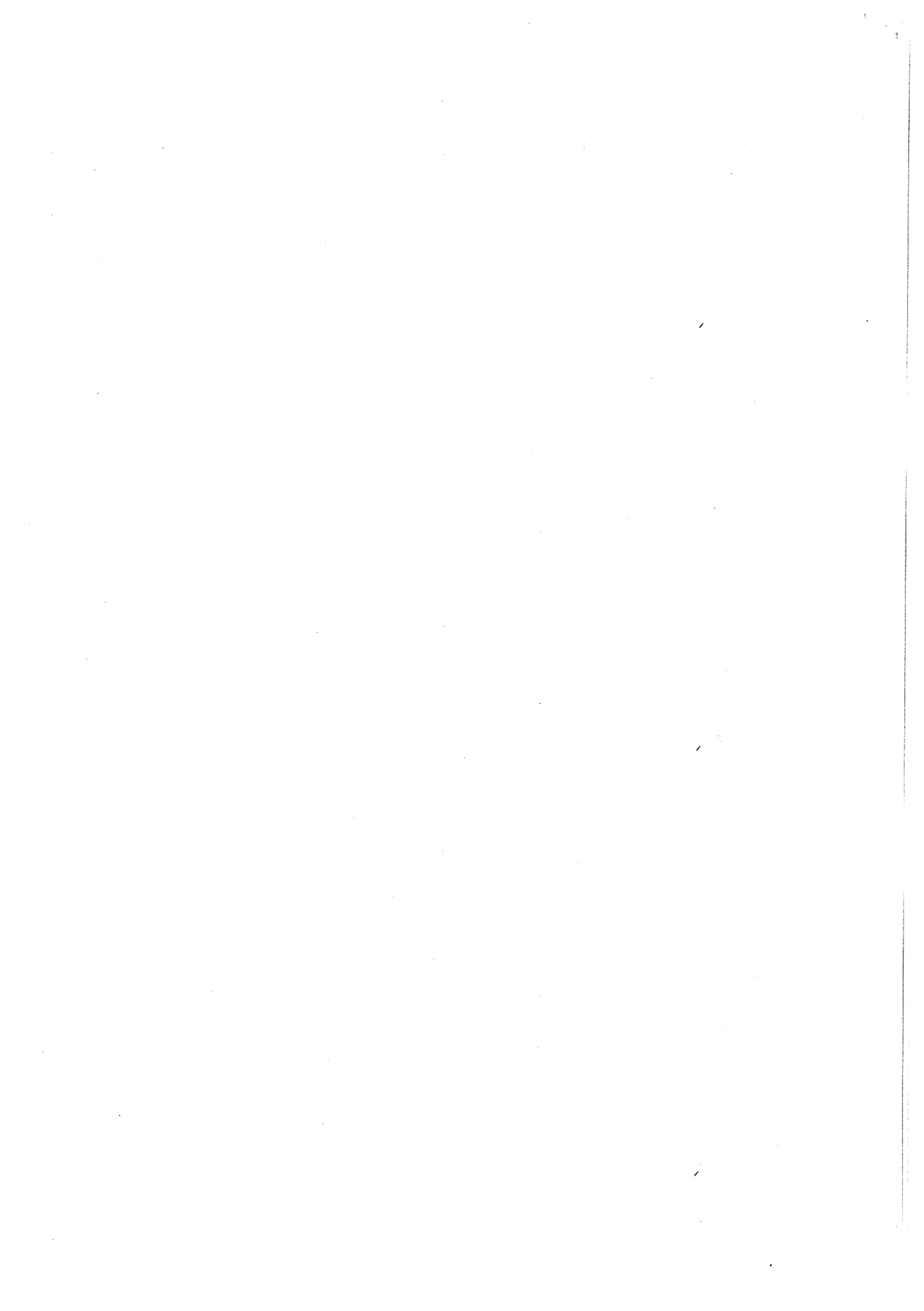
यह खाता केवल आयकर के लिए ही प्रयोग किया जा सकता है।
इस खाते में अन्य प्रकार के भुगतान नहीं की जा सकते।
यदि आप इस खाते का उपयोग करना चाहते हैं, तो आपको
यह - 411 010 नंबर पर कॉल करना होगा।

यदि आप इस खाते का उपयोग करना चाहते हैं, तो आपको
पता नंबर 411 010 पर कॉल करना होगा।
Income Tax PAN Services Ltd, 411 010
1st Floor, Mahatma Building,
Plot No. 441, Survey No. 2473,
Mandali Colony, Near Deep Mangalocharya Chowk,
Pune - 411 010.
Tel: 020-2731 0000, Fax: 020-2731 0001
E-mail: income@pan.in

Electronically Issued and Digitally signed PAN is a valid mode of issue of Permanent Account Number (PAN) post amendments in clause (t) in the Explanation occurring after sub-section (8) of Section 139A of Income Tax Act, 1961 and sub-rule (6) of Rule 114 of the Income Tax Rules.



எனது ஆதார, எனது அடையாளம்



Mrs. LALITHA A.V

71/Female/MF 00573

16/01/2024/II 2024000107

Dr. T. PALANIAPPAN

**Medway Hospitals®***The way to better health***HISTORY & PHYSICAL EXAMINATION FORM**

Patient's Name : Mrs. LALITHA

I.P. No. : 0107

Age : 71

Sex : M / (F)

Ward : 3rd floor

Room No. : 307

Consultant Dr. : Dr. T. PALANIAPPAN

D.O.P. : 16/1/24

Temp : 96.4° Pulse : 88

Resp : 20

Allergies : -

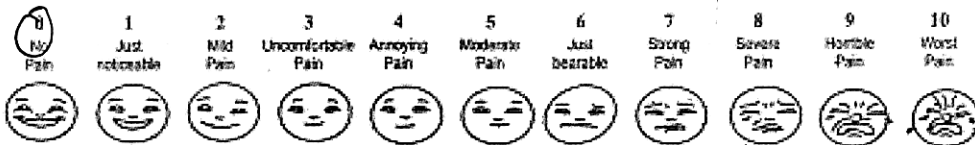
B/P : 110/80

Height : -

Weight : -

Current Medications : -

9802197

**Complaints**

A case of 71 years old female come in with clb. fatigue and giddiness on waking up since few months.

History of Present illness

No h/o any fever or cold or cough.

No h/o breathlessness

No h/o any bleeding manifestation.

Married since 40 years / NCM.

Past history of relevance

family

and

Personal

K/c/o CAD/T2DM on regular medication

H/o hospitalization in October 2023 for flu.

H/o LSCS & hysterectomy 20 years ago.

H/o Icterus HI @ &

Clinical Examination

O/E: pt is conscious, oriented, alert.

No pallor, no cyanosis, no clubbing.

No generalized lymphadenopathy / pedal edema.

S/E: A/S - S, S2A7, no murmurs

R/S - B/L A/S (T), no added sounds.

H/A - A/S, C/S - A/S.

CBG | RET | urine routine | ~~urine~~ urine ²⁵ ~~micro~~ ^{micro} ~~ab~~ ^{ab}
CBG & 2 hrs.

T2DM / DKA / Uncontrolled T2DM:

Monitor vitals.
CBG 2 hrly
IVF NS 10 150 ml/hr
INJ. HA 40/hr
INJ. GLUTABLISS IV STAT
INJ. TUS COOL 40mg IV BD

Da. C21

Dr. C. 184205 SRJ LASVA

Date : 16/01/2024 Time : 1:30 PM





DRUG CHART

MH/PRINT / 0042

Name of the Patient : Mrs. Lalitha A.V. Age 71 Sex F Bed No. 307
Clinical Diagnosis : T2DM / DM / Uncontrolled T2DM IP No. D107 Ht. ± Wt. ±
Primary Consultant Name : Dr. T. PALANIAPPAN PID No. 0573

Name of the Medicine	Dose	Route	Frequency	16/1/24	17/1/24	18/1/24
TAB. TRIPINOM	1 Tab	P/O	1/2-0-0			
TAB. NITROCONTIN 2.6 TAB 305	1 Tab	P/O	1-0-1			
TAB. ROSUVAS CV	10mg	P/O	0-0-1			
TAB. PROLOMET XL	25mg	P/O	1-0-0			
TAB. SHELICAL	500mg	P/O	1-0-0			
TAB. DUZEELA P	1 Tab	P/O	0-0-1			
TAB. HA	40/40	IV	40/40			
INJ. TUSCOOL	40mg	IV	BD			

Administered by (Nurse Signature) :

Verified by (DMO Signature) :

Nurse Signature : S. Rao

Nurse Name : S. THASINATH 2257

Date & Time : 16/1/24 @ 1.30pm

DMO Signature : Dr. C. Sri Lakshya

DMO Name : DR. C. SRI LAKSHYA

Date & Time : 16/01/2024 @ 1:30PM

Primary Consultant Signature : Dr. T. Palaniappan

Primary Consultant Name : Dr. T. Palaniappan

Date & Time : 16/1/24

Reg No. : 55530

Adverse Reaction, if any : _____

[illegible][illegible]