STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.
Corporate Office - Claims Dept. : No.15, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014.
Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522
CIN : U66010TN2005PLC056649 Email:support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

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 : STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

b. Toll free phone number:

c. Toll free fax:

d. Name of Hospital: MEDWAY HOSPITALS
No. 2, Old No. 26, 1st Main Road
United India Colony,
Kodambakkam, Chennai-600 0[illegible]

I.Address

ii.Rohini ID

iii.e-mail id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : Sundaramal. D.

B. Gender: ☐ Male ☑ Female ☐ Third Gender

C. Age: 72 (Years) / (Month)

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

E. Contact number: 9884849500

F. Contact number of attending Relative:

G. Insured Card ID number: 8339638-1.

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. Basheer Ahmed.

B. Contact number::

C. Nature of illness/Disease with presenting complaint : 40, Slid & fall in the

D. Relevant Critical Findings: Recidency at bathroom;

E. Duration of the present ailment 1 Days injury to (Lt) hip.

iv. Date of First consultation 29/1/24. (DD/MM/Y'YYY)

v. Past history of present ailment, if an nil

F. Provisional diagnosis: # (Lt) femur inter trochanteric
ICD I0 code

G. Proposed line of treatment:

I.	Medical Management	( )
II.	Surgical Management	(✓)
III.	Intensive care	( )
IV.	Investigation	( )
V.	Non-allopathic treatment	( )

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

i. Route of Drug Administration fr/oral

I. If surgical, name of surgery: Proximal femoral nailing (Lt) hip

i. ICD I0 PCS code - Nil -

J. If other treatment, provide details: - Nil -

K. How did injury occur:

L. In case of accident:

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

NA

M. In case of Maternity:

I. expected date of Delivery (DD/MM/Y'YYY)

DETAILS OF PATIENT ADMITTED

A. Date of admission : (DD/MM/YYYY) 19/01/24.

B. Time of admission: (HH:MM) _____

C. Is this 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. Osteoarthritis _____
iv. Asthma/COPD/Bronchitis _____
v. Cancer nil
vi. Alcohol/Drug abuse _____
vii. Any HIV or STD Related ailment _____
viii. Rheumatoid Arthritis _____
ix. Cerebrovascular Accident(Stroke) _____
I. Liver disease _____
xi. Kidney disease _____
xii. Any other ailment,give details _____

E. Expected number of Days/Stay in hospital : 4-5 Days

F. Level / Grade of Surgery: _____

G. Days in ICU: _____ Days

H. Room Type: Single AC

I. Per day room rent + nursing and service charges +patients diet: _____

J. Expected cost of investigation + diagnostic: _____

K. ICU Charges: _____

L. OT Charges _____

M. Professional fees Surgeon + Anesthetist fees + consultation Charges: _____

N. Medicines + Consumable + Cost of Implants (if applicable please specify): _____

O. Other hospital expenses if any: _____

P. All-inclusive package charges if any applicable : _____

Q. Sum Total expected cost of hospitalization : ₹ 2,80,000/-

DECLARATION

(Please read very carefully)

A. Name of the treating doctor : Dr Basheer. .

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

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 liom 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

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

Doctor's Signature

Date :_____Time:_____

DECLARATION BY THE PATIENT / REPRESENTATIVE

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

b. Payment to hospital is govemed 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/T.P.A not govemed 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 / 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 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".

Authorization to Star health and allied Insurance Co. Ltd

I am admitted in your Hospital _____ from _____

I hereby authorize Star health and allied Insurance Co. Ltd. and its representatives, who is my Health Insurer to seek any medical information / records from you or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given. In case they seek any such information / records / indoor case papers, kindly oblige.

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

b) Contact number : _____

c) e-mail Id : _____

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

Date : _____ Time : _____

Star Health And Allied Insurance Company Limited

Senior Citizens Red Carpet Health Insurance Policy
Unique Identification No. SHAHLIP22199V062122

In Consideration of payment of Rs. 26,550/- towards renewal premium of policy number:11220007830005, the policy stands renewed for a further period of 1 Year as per the details given below

Renewal Endorsement No:11220007830006			
Customer Code : 8339638		GSTIN	: 33AAJCS4517L1Z5
Customer Name : SUNDARAMMAL.D		SAC Code	: 997133 / Accident and Health Insurance Services
Proposer Code : 8339638		Issuing Office Code	: 111117
Proposer Name : SUNDARAMMAL.D		Issuing Office Name	: Branch Office - Pallavaram
Proposer Address : NO : 13 / 43, THOMAS STREET, THIRUVIKA NAGAR, KADAPPERI, WEST TAMBARAM, KANCHEEPURAM - 600 045. . . Tambaram Tamil Nadu 600045		Issuing Office Address	: No.3/1P, Zains Complex 2nd Floor, Dr.Rajendra Prasad Road Cantonment Pallavaram Pallavaram Taluka Tamil Nadu 600043
Phone No : 9884849500		Phone No	: 044-49030050
E-mail Id : srini_yamini3@yahoo.com		E-mail Id	: chennai.pallavaram@starhealth.in
Proposer GSTIN : NO		Place of Supply	: Tamil Nadu
Proposal date : 14-Dec-2017		Fulfiller Code	: SH51259
Date of Inception of first policy : 18-Dec-2017			
Renewal Year : Sixth Year		**Intermediary Code**	**: BA0000144568**
Collection No : 191034012001			
Collection Date : 18-Dec-2023		**Name**	**: R SELVAM**
Premium : Rs. 22,500/-		**Phone No**	**:9444491816/9094421816**
CGST @ 9% : Rs. 2,025/-		**E-mail Id**	**:rselvamlic@gmail.com**
SGST @ 9% : Rs. 2,025/-			
Total Premium : Rs. 26,550/-			
Stamp Duty : Re. 1/-			
Total Premium In Words : Rupees Twenty Six thousand five hundred fifty only			
PERIOD OF INSURANCE : From : 18-Dec-2023 00:00	**To :** Midnight Of 17-Dec-2024		**Policy Term :**1 Year
Installment Facility Option: No	**Premium Payment Frequency : Annual**		**Installment Amount Rs. : 0/-**
Policy Type : INDIVIDUAL			

Entered by : SH68080
Approved by : SH68080

IRDAI Regn.No.129

Corporate Identity Number L66010TN2005PLC056649

Email ID: info@starhealth.in

For Star Health and Allied Insurance Company Ltd.

Authorised Signatory

Regd.&Corporate Office:1,New Tank Street,Valluvar Kottam High Road,Nungambakkam,Chennai - 600034,Phone : 044 -28302700 / 28288800
Toll Free No:1800-425-2255 / 1800-102-4477,CIN : L66010TN2005PLC056649 Email :support@starhealth.in Website :www.starhealth.in
IRDAI Regn.no: 129

Star Health And Allied Insurance Company Limited

Attached to and forming part of Policy No: 11220007830006

Details of Insured Persons :

Sl. No.	Name	Gender	Date of Birth	Age in Yrs	Relationship with Proposer	ID Card No	OP Limit	Co-Pay	Sum Insured	Inception date
1	SUNDARAMMAL.D	Female	07-Feb-1950	73	Self	8339638-1	1,400	30	10,00,000	18-Dec-2017
Pre Existing Disease :	No PED Declared									

Nominee Details:

Nominee Details for the Proposer					Appointee Details		
S.No	Name	Relationship with proposer	Age	% of the claim	Appointee Name	Appointee Age	Relationship with nominee
1	D SRINIVASAN	Son	54	100			

Sector Classification:

Urban		Urban

"CONSOLIDATED STAMP DUTY PAID VIDE G.O.(RT) NO.244 DATED.2ND JUNE 2023"

Please check whether the details given by you about the insured persons in the proposal form are incorporated correctly in the policy schedule.If you find any discrepancy, please inform us within 15 days from the date of receipt of the policy, failing which the details relating to the insured person given in the policy schedule are deemed to have been accepted by you.

Warranted that in case of dishonour of premium cheque(s), the Company shall not be liable under the policy and the policy shall be void abinitio(from inception).

Expenses relating to the hospitalisation will be in proportion to the room rent stated in the policy.

Condition No. 4 regarding delay in payment of claim shall read as follows and not as stated in policy wordings: "The Company shall pay interest as per Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017, in case of delay in payment of an admitted claim under the Policy"

IMPORTANT

IN THE EVENT OF HOSPITALIZATION OF INSURED PERSON, INTIMATION SHOULD BE GIVEN TO THE COMPANY IMMEDIATELY, HOWEVER, WITHIN 24 HRS FROM THE TIME OF ADMISSION.

Toll Free No : 1800 425 2255 / 1800 102 4477 Email: support@starhealth.in Fax No: 1800 425 5522.

In the event of the policy being withdrawn in future, intimation about the withdrawal will be sent 3 months prior to the date when renewal falls due.The insured will have the option of migrating to any other similar health insurance policy offered by the Company at the relevant time. Continuity of benefits for waiting period and bonus, if any and if applicable, will be given provided the insured had been renewing the policy without any break (or renewing within the grace period offered)

It is hereby made clear that all terms, conditions, clauses, warranties, exclusions etc., as already issued, forming part of the policy of insurance originally issued at the time of inception of this relationship, shall continue to be operative and unaltered, forming part of this renewal insurance cover also.

Reference may be made to those terms, conditions etc., for identifying the scope/extent of coverage.

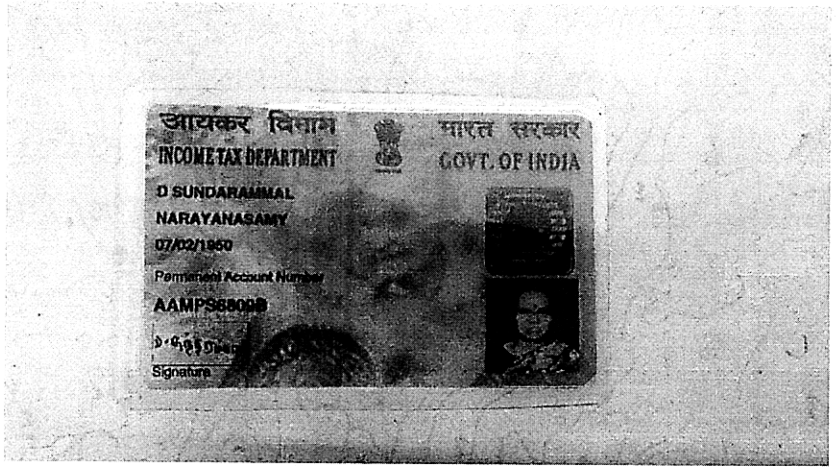
Other excluded expenses as detailed in our website www.starhealth.in

Entered by : SH68080
Approved by : SH68080

For Star Health and Allied Insurance Company Ltd.

Authorised Signatory

Regd.&Corporate Office:1,New Tank Street,Valluvar Kottam High Road,Nungambakkam,Chennai - 600034,Phone : 044 -28302700 / 28288800
Toll Free No:1800-425-2255 / 1800-102-4477,CIN : L66010TN2005PLC056649 Email :support@starhealth.in Website :www.starhealth.in
IRDAI Regn.no: 129


आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT. OF INDIA
D SUNDARAMMAL
NARAYANASAMY
07/02/1960
Permanent Account Number
Signature

19/01/2024.

From:

D. Srinivasan

S/O D. Sundarammal

No 43/13, Thomas Street, Thiru-Vi-Ka Nagar

Kadaperi, Tambaram

Chennai - 600045

To

Star Health Insurance

Respected Sir:-

Sub:-

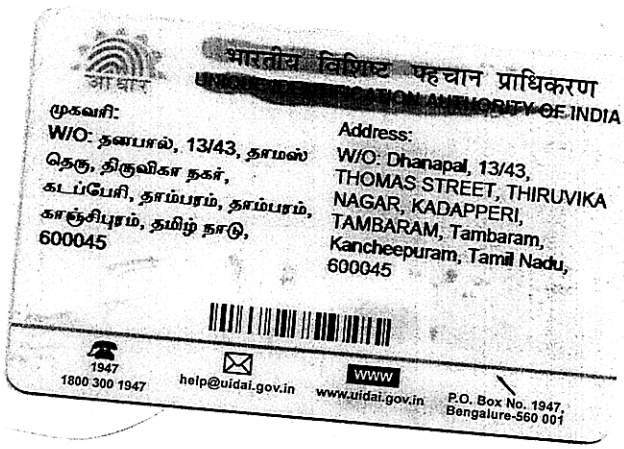
Patient named Sundarammal 73/F, fell down at her residence on 19/01/2024 (Friday) at 12:00Noon She was admitted at Deepam Hospital, Tambaram where first aid was given. Later, she was referred to Medway Hospitals, Kodambakkam, where Dr. Basheer Ahmed examined the patient & indicated that surgery has to be proceeded. So we are proceeding with the treatment.

Thanking You,

Yours faithfully

D. Srinivasan


भारत सरकार
சுந்தரம்மாள் தனபால்
Sundarammal Dhanapal
பிறந்த நாள் / DOB : 07/02/1950
பெண் / FEMALE
7675 4470 4798
ஆதார் - சாதாரண மனிதனின் அதிகாரம்


आधार
भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA
முகவரி:
W/O: தனபால், 13/43, தாமஸ் தெரு, திருவிகா நகர், கடப்பேரி, தாம்பரம், தாம்பரம், காஞ்சிபுரம், தமிழ் நாடு, 600045
Address:
W/O: Dhanapal, 13/43, THOMAS STREET, THIRUVIKA NAGAR, KADAPPERI, TAMBARAM, Tambaram, Kancheepuram, Tamil Nadu, 600045
1947
1800 300 1947
help@uidai.gov.in
www
www.uidai.gov.in
P.O. Box No. 1947, Bengalure-560 001

MH/PRINT /0054/ NRS

Medway Hospitals®

The way to better health

HISTORY & PHYSICAL EXAMINATION FORM

Patient's Name : Mrs Sundhoorambal

I.P. No. : 0138

Age : 72 yr Sex : M / F Ward : [illegible] Room No. : [illegible]

Consultant Dr. : Dr. [illegible]

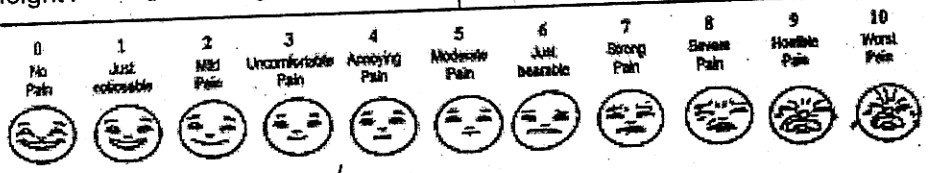
D.O.P. : 20/1/24

Temp : 98 P Pulse : [illegible] Resp : 22

B/P : 120/80 Height : — Weight : —

Allergies : NK

Current Medications :



Complaints

C/o skid & fall

History of Present illness

Pt Presented c H/o slip & fall in her Residences at bathroom @ Afternoon

pt sustained Injury to Left Hip

Restriction of Movement (+)

Past history of relevance

family and Personal

No H/o Bleeding Manifestation

no H/o Loc, ENT Bleed, Vomiting, Seizure

No H/o Head Injury

Clinical Examination

U/c/o T2DM on Medx

Not a HTN / Asthma / TB / CAD

Pt Conscious

oriented

Afebrile

CVS - N.S.1.A)

RS - BAE)

Continuation on the reverse side ☐

P/A - soft

CNS - NFND

L/E - tenderness in (L) Hip

ROM (↓)

Investigation required

Surgical pack

CXR, ECG, Echo

Diagnosis

(Lt) Femur Inter trochanteric #

Plan of Care

Admit ↓ Dr. Basheer (Orth), Plan for Sx @ 1100 hrs

NPO from 6:00 hrs

Get Cardiologist Opinion

Inj. Pan 40mg IV stat

Inj. Emeset 2cc IV stat

Preparation of parts

Plan of Sx - Proximal femoral Nailing (LT) Hip

Date : 19/1/24 Time : 7:30 pm

Signature

Examined by

Medway Hospitals®
The way to better health

DRUG CHART

MH/ PRINT / 00

Name of the Patient : mrs. SUNDARAMMAL Age 72 Sex F Bed No. 407

Clinical Diagnosis : IP No. 0132 Ht — Wt —

Primary Consultant Name : DR BASHEER AHMED PID No. 3112

Name of the Medicine	Dose	Route	Frequency	19/11/24	20/11/24
Inj PARACETAMOL	1gm	IV	1-0-1		
Inj PAN	40mg	IV	1-0-0		
Administered by (Nurse Signature) :					
Verified by (DMO Signature) :					

Nurse Signature : Bloss
Nurse Name : Bloss
Date & Time : 19/11/24

DMO Signature : 19/11/24
DMO Name : Dr Mohamed Rashee
Date & Time : 19/11/24

Primary Consultant Signature :
Primary Consultant Name : DR BASHEER AHMED
Date & Time : 19/11/24
Reg No

Dr. P. BASHEER AHMED
M.B.B.S., D.Ortho, Mch (Ortho)
Fellow Arthroplasty (Australia)
Senior Consultant Orthopaedic Surgeon
Specialist in Trauma,Joint Replacement & Arthroscopy)

Medway

Mrs Sundaramal

I/p

IT # (Lt) Hip

(1) Planned for Proximal femoral nailing (Lt) hip tomorrow.

(2) [illegible] Blood for Grouping

Req
Chest x-ray PA view
Echo-Heart

(3) Cardiologist Fitness

(4) Syp. Paracetamol 2 BD

(5) Syp. Pan 2 OD
4 x ...

10/11/2024

2/26,1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 2473 4455
#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959
No. 8/22, 4th Cross Street, Trustpuram, Kodambakkam, Chennai - 600 024. Tel : 044-2473 4454
PC7 & PC7A, Block : 4 Bharathi Salai, Nolambur Mogappair west, Chennai - 600037 Tel : 044- 26530011
No.142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai, Ammachathiram (Post), Thiruvidaimarudhur (Taluk), Kumbakonam - 612103. (Tanjore Dist). Tel: 0435 - 2412345
E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com