Iw

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: [stamp: MEDWAY HOSPITALS, No. 2, Plot No. 36, 1st Main Road, United India Colony, Kodambakkam, Chennai-600 024]

Hospital location:

Hospital ID:

Hospital email ID:

ROHINI ID:

DETAILS OF THIRD PARTY ADMINISTRATOR

a) Name of TPA company: Medi Assist Insurance TPA Pvt Ltd b) Phone no.: 080 22068666 c) Toll Free Fax no.: 1800 425 9559

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient: Saroja.

b) Gender: ☐ Male ☑ Female ☐ Third gender c) Contact no.: 7299185056 d) Alternate contact no.:

e) Age: Years 76 Months f) Date of birth: D D M M Y Y Y Y g) Insurer ID card no.: 503396847

h) Policy number/Name of corporate: i) Employee ID:

j) Currently do you have any other medical claim/health Insurance: ☐ Yes ☑ No j.1) Insurer name:

j.2) Give details:

k) Do you have a family physician, if yes: Name: — k.1) Contact no.:

l) Occupation of insured patient:

m) Address of insured patient:

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor: N. Palaniappan b) Contact no.:

c) Name of Illness/disease with presenting complaints: 40, COPD, Systemic HTN, Hypothyroidism.

d) Relevant clinical findings:

e) Duration of the present ailment: 15 days e.1) Date of first consultation: 20 01 24

e.2) Past history of present ailment if any: nil

f) Provisional diagnosis: Type II Respiratory failure / Acute Excacerbation

f.1) ICD 10 code:

g) Proposed line of treatment: ☑ Medical management ☐ Surgical management ☑ ~~Intensive care~~ ☐ Investigation ☐ Non-Allopathic treatment

h) If investigation and/or medical management, provide details: Enclosed

h.1) Route of drug administration: ☑ IV ☑ ~~Oral~~ ☐ Other Enclosed

i) If Surgical, name of surgery: nil

i.1) ICD 10 PCS code:

j) If other treatments provide details: —

k) How did injury occur: —

l) In case of accident: I. Is it RTA: ☐ Yes ☐ No ii. Date of injury: D D M M Y Y Y Y iii. Reported 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 reports: ☐ Yes ☐ No

NA

m) In case of maternity: G P L A n) Expected date of delivery: D D M M Y Y Y Y

DETAILS OF THE PATIENT ADMITED

a) Date of admission: 20 01 24 b) Time of admission: H H M M c) This is ☐ an emergency/ ☐ a planned hospitalization event

d) Expected no. of days stay in hospital: Days e) Days in ICU: Days f) Room type: Sw.

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g) Per Day Room Rent + Nursing & Seryice 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. 1,50,000

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:

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

Doctor's signature:

Date: Time:

E-Card

The New India Assurance Co. Ltd.

Saroja

Name	Saroja
Member Id	5033968847
Date of Birth	10-Mar-1947
Relation	Mother
Effective From	01-Apr-2019
Policy Holder	The Hongkong & Shanghai Banking Corporation Ltd
Insurer Member Id	MEMBER1102

आयकर विभाग
INCOME TAX DEPARTMENT

भारत सरकार
GOVT. OF INDIA

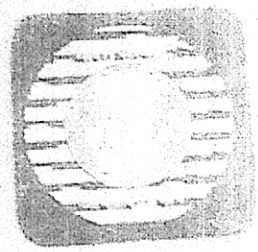
ROBERT ALLEN
GEORGE ALLEN

29/06/1973

Permanent Account Number

AEVPA7880H

Signature



Government of India

Robert Allen

Father : George Allen

Male

5954 8004 8759

HSBC

Robert

Allen

இந்திய அரசாங்கம்

Government of India

சரோஜா

Saroja

பிறந்த தேதி/DOB: 10/03/1947

பெண்பால் / Female

4348 3626 5091

ஆதார் - சாதாரண மனிதனின் அதிகாரம்

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

Unique Identification Authority of India

ஆதார்

முகவரி: W/O: ஆலன், 62

7 வது குறுக்கு தெரு, டிரஸ்ட்புரம்

கோடம்பாக்கம், கோடம்பாக்கம், சென்னை

தமிழ் நாடு, 600024

Address: W/O: Aalan, 62, 7
TH CROSS STREET,
TRUSTPURAM,
Kodambakkam,
Kodambakkam, Chennai,
Tamil Nadu, 600024

4348 3626 5091

1947
1800 300 1947

help@uidai.gov.in

Unique Identification Authority of India

முகவரி:
எஸ்/ஓ: ஜார்ஜ் ஆலன், 12,
இரண்டாவது தெரு பார்வதிபுரம்
திருநீர்மலை ரோடு,
திருநீர்மலை, குரோம்பேட்டை,
காஞ்சிபுரம், தமிழ் நாடு, 600044

Address:
S/O: George Allen, 12,
STREET PARVATHIPURAM
THIRUNEERMALAI ROAD
Thiruneermalai, Chrompet,
Kancheepuram, Tamil Nadu,
600044

5954 8004 8759

1947

help@uidai.gov.in

www.uidai.gov.in

Investigation required

→ CBC / RFT / LFT / (NT PRO BNP)
- Echo /
- Urine R/E
- Covid Influenza Viral Panel
- CT-Chest.

ABG
Hypoxia
+ Hypercapnia

Diagnosis

→ VIRAL / ATYPICAL PNEUMONITIS
→ HFrEF
→ TYPE II RESPIRATORY FAILURE
- ACUTE EXACERBATION OF COPD

Plan of Care

→ RV ADMISSION
→ NIV / BIPAP Support.
- NEBULISATION + STEROIDS
- PULMONOLOGIST OPINION
- CARDIOLOGIST OPINION
→ ANTIVIRAL / ANTIBIOTICS.
→ DIURETICS.
- FAMILY UPDATE

+ Target SpO_2 - 92%

Repeat ABG 5pm

Date : 2011/24 Time : 12 pm

Signature

Examined by Dr Haseeb

Medway Hospitals ®
The way to better health

DRUG CHART

MH/ PRINT / 0042 / NRS

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

Clinical Diagnosis : .....

Primary Consultant Name : .....IP No.....Ht.....Wt.....

.....PID No. .....

Name of the Medicine	Dose	Route	Frequency
Syp. DUPHALAC	15ml	PO	0-0-1
Inj. CLEXANE	0.4ml	S/C	OD.
Tab. THYRONORM	75mcg	PO	1-0-0
Tab. TELMA	40mg	PO	1-0-0

Administered by (Nurse Signature) :

Verified by (DMO Signature) :

Nurse Signature :

Nurse Name :

Date & Time :

DMO Signature : Dr. Bonas.

DMO Name :

Date & Time :

Primary Consultant Signature : Dr. Bonas.

Primary Consultant Name :

Date & Time :

Reg No. :

Allergic to .....Adverse Reaction, if any

MH/PRINT /0064/ NRS

Room No. :

Dr. Name :

Name :

Mrs.SAROJA A
76/Female/MI 31318
20/01/2024/II 2024000144
Dr.T.PALANIAPPAN

Medway Hospitals®
The way to better health

I P INSTRUCTION AND MONITORING CHART

Date		20/1/24			21/1/24			22/1/24												
PR	BP	Day / Night									Day / Night			Day / Night			Day / Night			Day
		12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	Temp.
																				106°
																				105°
																				104°
																				103°
																				102°
																				101°
																				100°
																				99°
																				98.6° 98°
																				97°
Hb/plt																				
Urea / Creat																				
CBG																				
RX																				
Inv		CBC RFT LFT NITROBENZ			TC, Cr, K+, Na+ Urea.															
ABX																				
Culture																				
Misc																				

20.01.2024 20:29:38
Medway hospitals

chennai

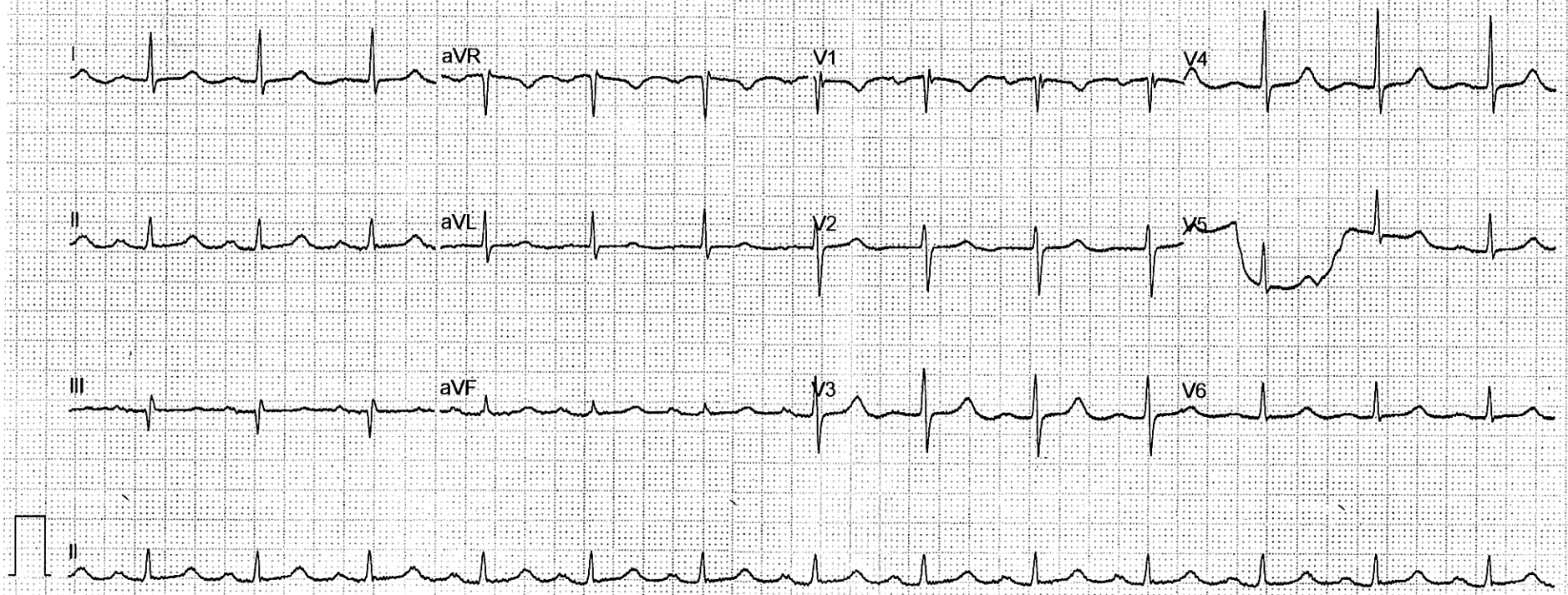
Location:
Room:
Order Number:
Indication:
Medication 1:
Medication 2:
Medication 3:

80 bpm
-- / -- mmHg

QRS	68 ms
QT / QTcBaz	416 / 479 ms
PR	196 ms
P	58 ms
RR / PP	750 / 750 ms
P / QRS / T	45 / 19 / 47 degrees

Normal sinus rhythm
Normal ECG

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:



[redacted]E MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-40 Hz 50 Hz 4x2.5x3_25_R1

Unconfirmed

1/1

MH/PRINT /0054/ NRS

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The way to better health

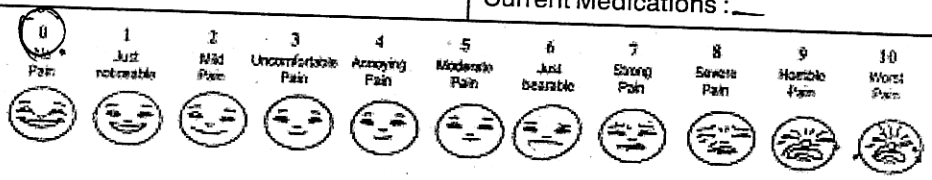
HISTORY & PHYSICAL EXAMINATION FORM

Mrs.SAROJA A
76/Female/MP 31318
20/01/2024/II 2024000144
Dr.T.PALANIAPPAN

Patient's Name		I.P. No.	:
Age	/ F	Ward :	Room No. : 210.
Consultant Dr.			D.O.A. : 20/1/24

Temp : 98.6°C Pulse : 80nts Resp : 22nts
B/P : 120/80 Height :- Weight : —

Allergies : Nil
Current Medications :—



Complaints

72 year old female, Known c/o COPD, Systemic HTN, Hypothyroidism, Dyslipidemia, ~~T2DM on medication~~ ; presented with H/o Breathing difficulty since past 15 days, gradually worsening, H/o cough & Expectoration past 15 days.

History of Present illness

Past history of relevance — family and Personal

H/o multiple falls at home → ? Syncopal Attack or weakness.

Past H/o (L) tibial Sx.

Clinical Examination

O/E- Patient Conscious, oriented.
PR- 68/min
BP- 130/70 mHg
CVS- S_1S_2
RS- B/L AE (+) wheeze (+) crepts (+).
→ Pedal edema (+).

Continuation on the reverse side ☐