FUTURE GENERALI
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: Chinnaponnu . K Health Card No. FGH M 1359982 E

Gender: ☐ Male ☑ Female Age: 74 (yrs) DOB: _____ Policy No: _____

Patient/Attendant Mobile No. _____ Employee ID _____ Company Name _____

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: 25/01/24 Time of Admission _____

Expected Length of Stay: _____ (days) Name of Treating Doctor: Dr. T. Palaniappan Mobile No: 9787664197

Nature of Illness / Disease with Presenting Complaints: c/o, chest pain, palpitation x 1 day
B/L . Lower . limb

Relevant Clinical Findings: Nil

Duration of present Ailment: 1 Years _____ Months _____ Days Date of First Consultation: _____

Past History of Present Ailment if any _____

Provisional Diagnosis: R/O, unstable Angina ICD Code: _____

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

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

Route of Drug Administration: I/V Lord If Surgical, Name of Surgery: _____

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: NA

How did injury occur: _____

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 NA

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 ☐	Nil
Cardiovascular Diseases	Yes ☐	No ☐	
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 ☐	

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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	₹ 2,30,000 /-		

Estimate of Expenses: Total Amount Rs. ₹ 2,30,000 /- Class of Accommodation: Twin

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: Dr. Balaji Appan Qualification:

MCI Registration No with State Code:

Signature of Doctor: Stamp / Seal of Hospital

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: Chinnaraju V. 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 Chinnaraju V. 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: Doctor's Signature:

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

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

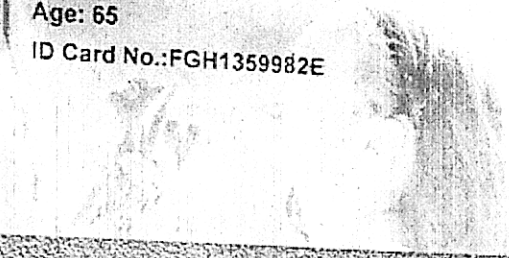
Name: K Chinnaponnu

Gender: Female

Age: 65

ID Card No.:FGH1359982E

Health



GOVERNMENT OF INDIA

வெங்கடேசன் கி

Venkatesan K

பிறந்த நாள்/ DOB: 22/03/1975

ஆண் / MALE

5922 3035 6636

எனது ஆதார், எனது அடையாளம்

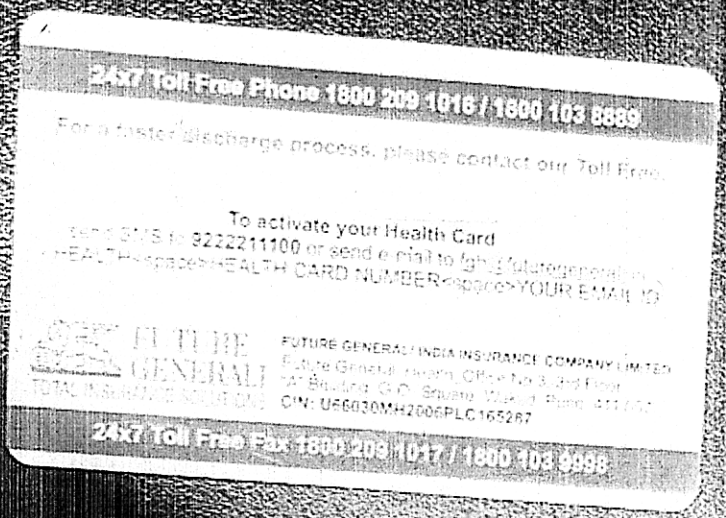
K.VENKATESAN

S/o:J.Krishnan

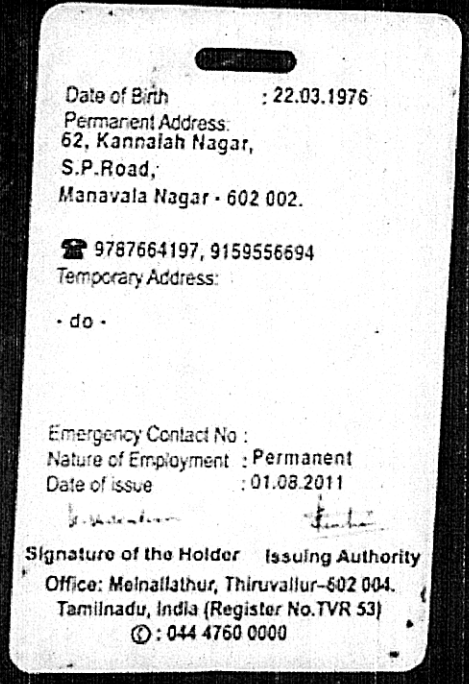
PS ID : 0358830

Blood Group : B+ve

CATERPILLAR


24X7 Toll Free Phone 1800 209 1016 / 1800 103 8899
To activate your Health Card
FUTURE GENERALI INDIA INSURANCE COMPANY LIMITED
CIN: U66030MH2006PLC165267
24X7 Toll Free Fax 1800 209 1017 / 1800 103 9998


भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA
முகவரி:
S/O கிருஷ்ணன், எண் 62,
எஸ் பி ரோட், கண்ணையா
நகர், வெங்கத்தூர்
கண்டிகை , மணவாளநகர்,
வெங்கத்தூர், திருவள்ளூர்,
தமிழ் நாடு - 602002
5922 3035 6636
1947
1800 300 1947
help@uidai.gov.in
www.uidai.gov.in
P.O. Box No. 1947,
Bengaluru-560 001


Date of Birth : 22.03.1976
Permanent Address:
62, Kannaiah Nagar,
S.P.Road,
Manavala Nagar - 602 002.
9787664197, 9159556694
Temporary Address:
- do -
Emergency Contact No :
Nature of Employment : Permanent
Date of issue : 01.08.2011
Signature of the Holder
Issuing Authority
Office: Melnallathur, Thiruvallur-602 004.
Tamilnadu, India (Register No.TVR 53)
: 044 4760 0000

MH/PRINT /0054/ NRS

Medway Hospitals®

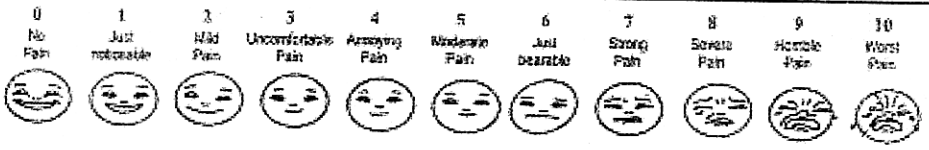
The way to better health

HISTORY & PHYSICAL EXAMINATION FORM

Mrs.CHINNA PONNU K
74/Female/MH202473269
25/01/2024/I 2024000184
Dr.T.PALANIAPPAN

Patient's Name :		I.P. No. :	
Age :		Ward :	Room No. : Pew.
Consultant Dr. :			D.O.P : 25/1/24

Temp : Afeb	Pulse : 80	Resp : 20	Allergies :—
B/P : 120/70	Height : 160 cm	Weight : 56 kg	Current Medications : —



Complaints

PAPILLOMAS & CANCER PAINT SPICAS RICE PAIN SINCE MONTHS

BLEEDING GUMS & NUB PAIN SINCE X 1 MONTH

ASSOC E DIFFICULTY WALKING

History of Present illness

Past history of relevance

family and Personal

c/o DM/ HTN/ CAD

Clinical Examination

CVS – S1 S2

RS – NAD

P/A – Soft

CNS – NAD.

Continuation on the reverse side ☐

Investigation required

Diagnosis

T2 RI. UNSTABLE ANGINA

B/L OA KNEE

DM | HTN

Plan of Care

ORTHO REFER

ANGIOGRAM

Date 25/1/24 Time : 7.50pm

Signature

Examined by DR MANU

Medway Hospitals®
The way to better health

DRUG CHART

MH/ PRINT / 0042 / NRS

Name of the Patient : .....
Clinical Diagnosis : .....
Primary Consultant Name : .....

Mrs.CHINNA ONNU K
74/Female/MR H202473269
25/01/2024/II 2024000184
Dr.T.PALANIAPPAN

..... Age..... Sex..... Bed No. .....
.....IP No.....Ht.....Wt.....
.....PID No. .....

Name of the Medicine	Dose	Route	Frequency	26/1/24				27/1/24			
T. ECOSPRIN	75mg	P/o	0-1-0		2 PM				2 PM		
T. ATORVAS	20mg	P/o	0-0-1			8 PM				8 PM	
T. MET XL	25mg	P/o	1-0-0	8 AM			8 PM				
T. PAN	40mg	P/o	1-0-0	7 PM		8 PM	8 PM				
T. ULTRACET	1 tab	P/o	1-0-1.	2 PM		2 PM	8 PM			8 PM	
Administered by (Nurse Signature) :											
Verified by (DMO Signature) :											

Nurse Signature : S/N Hema
Nurse Name : Hema
Date & Time : 26/1/24

DMO Signature :
DMO Name : DR ANISH
Date & Time : 26/1/24.

Primary Consultant Signature : for Hema
Primary Consultant Name : DR. T. PALANIAPPAN
Date & Time : 26/1/24.
Reg No. : 55830

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

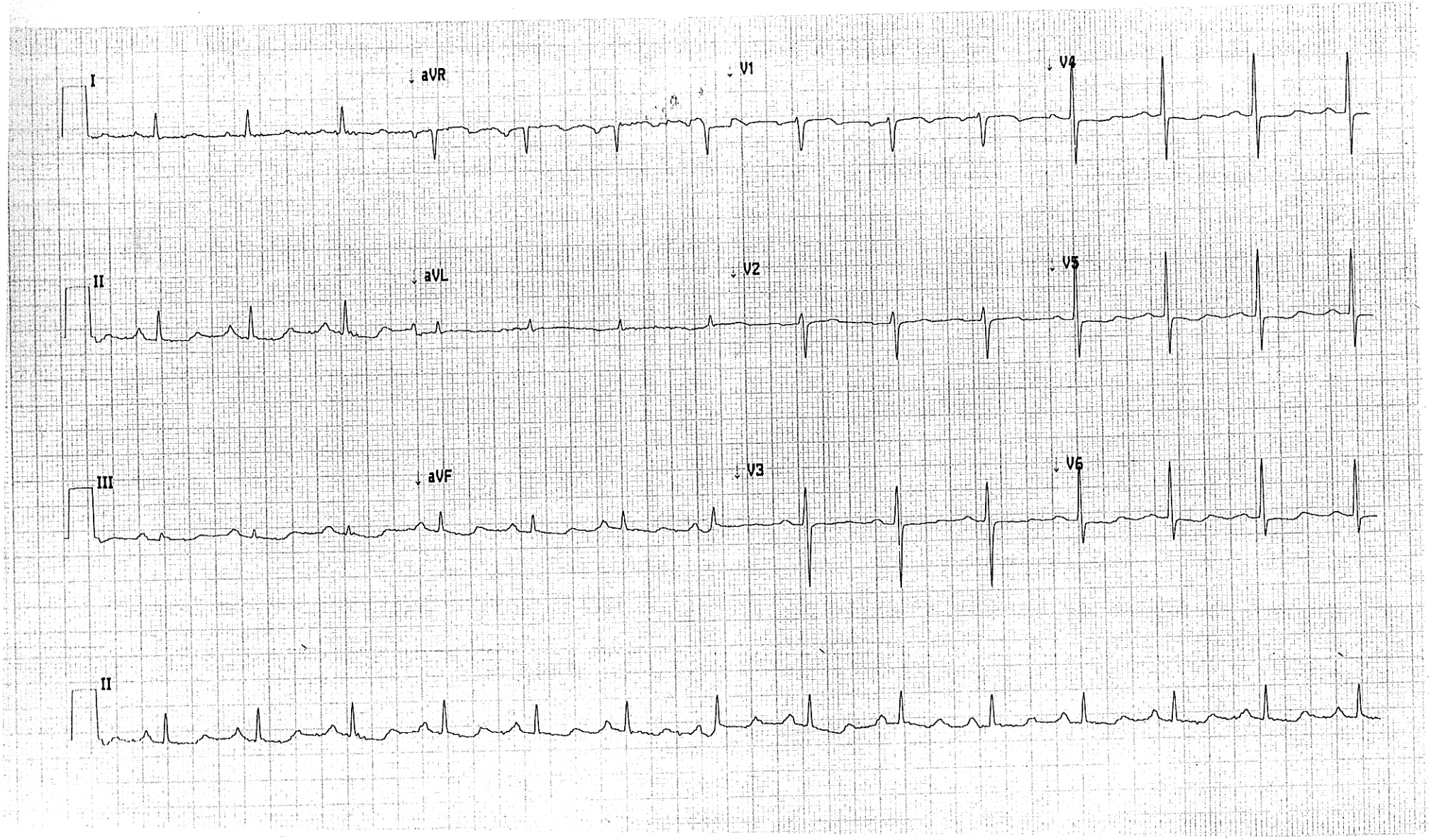
DOB:
0yr, FEMALE

25-Jan-2024 10:49:27

Vent rate:	83 BPM
PR int:	185 ms
QRS dur:	81 ms
QT/QTc:	387/427 ms
P-R-T axes:	67 39 62

..PEDIATRIC ECG INTERPRETATION
SINUS BRADYCARDIA WITH PROLONGED PR FOR AGE
BORDERLINE ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 6 MONTHS

Reviewed by _____



PATIENT NAME	MRS.CHINNA PONNU K	PATIENT ID	MMH202473269
CONSULTANT	DR. T. PALANIAPPAN	AGE/ GENDER	74Y/FEMALE
IP/ OP	IP-00184	STUDY DATE	25.01.2024

ECHOCARDIOGRAM REPORT

Aorta: 23**mm** (25-37mm) **Left Atrium:** 25**mm** (19-40mm)

Result		Normal Range	Result		Normal Range
LVIDD	40mm	33-55mm	EDV	70ml	56-104 ml
LVIDS	27mm	24-42mm	ESV	28ml	19-49 ml
IVSD	08mm	6-11mm	EF	59%	55-75 %
LVPWD	08mm	6-11mm	FS	31%	30-40 %

VALVE:

Mitral Valve : Normal.
Tricuspid Valve : Normal.
Aortic Valve : Sclerosis
Pulmonary Valve : Normal.

CHAMBERS:

Left Ventricle : Normal.
Left Atrium : Normal.
Right Ventricle : Normal.
Right Atrium : Normal.

SEPTUM:

IAS : Intact
IVS : Intact

PATIENT NAME	MRS.CHINNA PONNU K	PATIENT ID	MMH202473269

DOPPLER PARAMETERS:

VALVES	VELOCITY MAX(m/sec)	MAX GRADIENT (mmHg)	MEAN GRADIENT(mmHg)
AORTIC	0.9	3	2
MITRAL	0.5/0.8		
TRICUSPID	1.9		
PULMONARY	0.8		

MEDIAL E/E' : 8.07
LATERAL E/E' : 6.66
E/A RATIO : 0.69
TRPG: 15mmHg
RVSP: 25mmHg

IMPRESSION:

- CHAMBERS NORMAL SIZED.
- NO REGIONAL WALL MOTION ABNORMALITY.
- NORMAL LV SYSTOLIC FUNCTION.
- GRADE I DIASTOLIC DYSFUNCTION
- NORMAL RV SYSTOLIC FUNCTION **RVTDI:** 12cm/s, **TAPSE:** 22mm
- AORTIC VALVE SCLEROSIS
- OTHER VALVES STRUCTURALLY NORMAL.
- TRIVIAL TR / NO PAH
- IVC NORMAL IN SIZE AND COLLAPSING
- NO VEGETATION / EFFUSION / CLOT

HEART RATE: 80bpm

DONE BY
MS.KAMALEESHWARI.K
(CARDIAC TECHNOLOGIST)