

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

TO BE FILLED IN BLOCK LETTERS

Name of the hospital:
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: Lakshmi
b) Gender: ☐ Male ☒ Female ☐ Third gender c) Contact no: 9808064446 d) Alternate contact no:
e) Age: Years 35 Months 00 f) Date of birth: 20/01/1989 g) Insurer ID card no: 5077072486
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: M. Kumar b) Contact no:

c) Name of illness/disease with presenting complaints: 40, acute lower back pain d) Relevant clinical findings: radiation of pain (RP) lower limb, constant pain of

e) Duration of the present ailment: 1 days e.1) Date of first consultation: 09/01/24 Lower limb

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

f) Provisional diagnosis: Lumbar spondylosis & acute (RP) side LVP - L4, L5 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: (for local) analgesic h.1) Route of drug administration: ☒ IV ☐ Oral ☐ Other Oral

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: 09/01/24 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

m) In case of maternity: G P L A n) Expected date of delivery: NA

DETAILS OF THE PATIENT ADMITTED

a) Date of admission: 30/01/24 b) Time of admission: 11:00 AM 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: Single

PART C (Revised)

- g) Per Day Room Rent + Nursing & Service charges + Patient's Diet:
- h) Expected cost for investigation + diagnostics:
- i) ICU Charges:
- j) OT Charges:
- k) Professional fees Surgeon + Anesthetist fees + Consultation charges:
- L) Medicines + Consumables cost of Implants: (specify if applicable)
- m) Other hospital expenses if any:
- n) All inclusive package charges if any applicable :
- o) Sum Total expected cost of hospitalization

☐	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:

a) Name of the treating doctor: M P V N A R C Y K

b) Qualification:

c) Registration No. with State code:

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:

- 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.

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.

RENEWAL HOSPITALS
No. 2, Old No. 40, 1st Main Road,
United City, Colombo.



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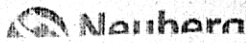
WILLIAM A. GIBB INSURANCE TRUST LTD.

645000 1003 1247 9 771

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11/15/2011 11:11:11 AM

ADDRESS ONLY: _____



Dr. G.K. Kumar, MD, DA, FIPP, DHSc (Ac),

Fellow of Interventional Pain Practice (FIPP-USA),
Pain Physician & Intervention Pain Specialist

Mr. K. Lakshmi 75/11

23.1.24

Kindly admit for management of LBR

Kindly take MRI Lumbosacral area

R (Right) leg (Right) leg

U10 LBR + R leg radioculac pain
x 5 m

to R10 WOP + n' Root compression

Right leg (R)

Dr. G.K. KUMAR, MD, DA, FIPP, DHSc (Ac),
Fellow of Interventional Pain Practice (FIPP-USA),
Pain Physician & Intervention Pain Specialist

Ly No 10699



THE PAIN CLINIC

An Exclusive Pain Management Center with Advanced Interventional Facilities

No. 25, 2nd Floor, 100 Feet Road, Next to Aarthy Mahal, Vadapalani, Chennai - 25

☎ 044-2432265 📠 63693 66676 ✉ painclinicdoctor@gmail.com 🌐 www.chennaipainclinic.com

" TOWARDS A PAIN FREE WORLD "

Stroke / Blood thinners
Clopidogrel / Aspirin / NSAIDs ☐ Clopidogrel Genotyping ☐ ADA + HbA1c / Body mass

☐ Master Health Checkup ☐ Geriatric health Checkup (MHC+PSA)

For PT & aPTT Please indicate ☐ Pre-operative Monitoring OAT Monitoring Heparin / LMWH

Signature

(PIC for Health Practitioners & Patients)



இந்திய அரசாங்கம்
Government of India



கி. லக்ஷ்மி
K Lakshmi
பிறந்த நாள்/DOB: 12/06/1948
புணர்/ FEMALE



6486 6585 5281

VID: 9129 9887 2072 6431

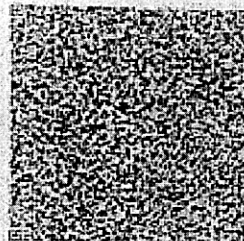
எனது ஆதார், எனது அடையாளம்



பெரும்புலையிலுள்ள திருவள்ளூர் அமைதி, அமைதி
Unique Identification Authority of India

முகவரி:
C/O ஜெசுவராய் ராஜ், புதிய எண் 163/1,
பழைய எண் 59, 2வது தளம், ஹபிபுல்லா
ரோடு, தியாகராய நகர், சென்னை,
தமிழ்நாடு - 600017

Address:
C/O Jejeswara Rao, NEW NO 163/1, OLD
NO 59, 2ND FLOOR FL, HABIBULLAH
ROAD, Thyagaraya Nagar, Chennai,
Tamil Nadu - 600017



QR Code with Photo/Signature

6486 6585 5281

VID: 9129 9887 2072 6431

TAPE

Udaya Bhaskar K



Blood Group : O+ve

Employee No : E9448

Wampals

Issuing Authority

Holder's Signature

K Udaya Bhaskar

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

Patient's Name : Mrs Lakshmi

I.P. No. : 0216

Age : 75

Sex : M / F

Ward : Ortho

Room No. : 402

Consultant Dr. Dr. Kumar GK

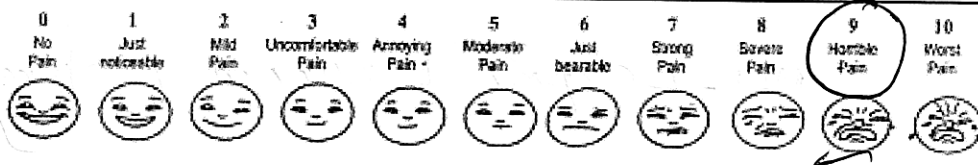
D.O.A : 29/1/24

Temp : 98.4 F Pulse : 86/min Resp : 20/min

Allergies : -

B/P : 130/70 Height : - Weight : -

Current Medications : -

SpO2 97%
mmHg**Complaints**

Pt. came to hospital with 40% acute lower back pain & radiation of pain to

(R) - lower limb, continuous pain,

History of Present illness

mechanical in nature, which recent involvement of (L) - lower limb

- No H/o - bladder, bowel involvement but has positive cough impulse (L)

Past history of relevance

family

and

Personal

- K/O - SHOL on Regular medication

- S/P - Hypertension

- S/P - Cholelithiasis

Clinical Examination

O/E: conscious, oriented, afebrile

S/E:

MS: S1S2 (+)

IS: BAF (+)

LE:-

SLR (R) -40°

(L) -70°

- well leg rising test is positive
- Rock tensor sign are positive

Investigation required

MRI - L5 spine to rule out Piriformis syndrome

Hb, Platelets, Coagulation profile, Serology, RBS, Sr. Urea, Sr. Creatinine.

Diagnosis

Δ: Lumbar spondylosis with acute (R) sided NIDP - L4-L5-L5-S1, with radicular symptoms with no motor involvement

Plan of Care

pt. admits under Dr. G.K. Kannan.

plan: Epidural injection (steroid)
on 29-1-24

Signature

Examined by

Elango
13/1/24

Dr. Sri Elango Kannan-P

Date: 29-1-24 Time: 10:30 am



Laboratory Test Result

Patient Name	: Mrs.LAKSHMI KILLAMPALLI	Patient Id	: MH04275
Visit No	: IP2024000216	Sample ID	: MHNA23792
Age	: 75	Order Date	: 29/01/2024
Gender	: Female	Collection Date & Time	: 29/01/2024 10:40:42AM
Visit Type	: IP	Receiving Date & Time	: 29/01/2024 11:13:39AM
Patient Ph No	: 9003064446	Report Date & Time	: 29/01/2024 12:22:05PM
Ward/Bed	: ELITE SINGLE / E4	Doctor Name	: Dr.KUMAR GK

Investigation	Value	Unit	Biological Reference Value
HAEMATOLOGY			
BLEEDING TIME	" 01 " MINS " 45 "	Mins	01 - 03
(Method :)	SECS		
(Specimen : NA)			
CLOTTING TIME	" 04 " MINS " 00 "	Mins	03 - 07
(Method : Capillary method)	SECS		
(Specimen : NA)			
HAEMOGLOBIN	<u>11.8</u>	g/dL	12 - 15
(Method : Colorimetric)			
(Specimen : Whole blood)			
PLATELET COUNT	278000	Cells/cu mm	150000 - 400000
(Method : Electrical Impedence)			
(Specimen : Whole blood)			
APTT			
ACTIVATED PARTIAL TROMBOPLASTIN TIME (aPTT)	<u>23.4</u>	secs	26 - 40
(Method : Turbodensitometric photo optical measuring)			
(Specimen : Plasma)			
PROTHROMBIN TIME			
TEST	11.1	secs	11 - 15
(Method : Turbodensitometric photo optical measuring)			
(Specimen : Plasma)			

Dr.Monica Kumbhat.,

LAB DIRECTOR

VANMATHI T

Result Entered By



Tests marked with NABL symbol are accredited by NABL vide Certificate no MC- 5409

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#5/11, Corporation Colony Main Road, Rangarajapuram, Kodambakkam, Chennai - 600024
Contact No : 044-35007072 / +91 72990 67800 | email : medwaymedicallabs@gmail.com

PATIENT HELPLINE
94457 94457
1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam	Mogappair	Kumbakonam	Chengalpattu	Villupuram
044-2473 4455	044-26530011	044-2473 4455	044-27426829	04146-242000

Heart Institute
044 - 4310 8959

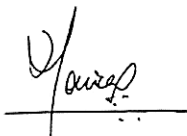
Institute of Pulmonology
044-2473 4451

E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665



Patient Name : **Mrs.LAKSHMI KILLAMPALLI** Patient Id : MH04275
Visit No : IP2024000216 Sample ID : MHPla23794
Age : 75 Order Date : 29/01/2024
Gender : Female Collection Date & Time : 29/01/2024 10:40:42AM
Visit Type : IP Receiving Date & Time : 29/01/2024 11:13:39AM
Patient Ph No : 9003064446 Report Date & Time : 29/01/2024 12:22:05PM
Ward/Bed : ELITE SINGLE / E4 Doctor Name : Dr.KUMAR GK

Investigation	Value	Unit	Biological Reference Value
CONTROL	12.1	secs	
(Method : MNPT)			
(Specimen : Plasma)			
INR	0.9	secs	0.9 - 1.3
(Method : Calculated)			
(Specimen : Plasma)			
BIOCHEMISTRY			
 CREATININE	0.71	mg/dL	0.6 - 1.1
(Method : Jaffes)			
(Specimen : Serum)			
 UREA	31	mg/dL	12.8 - 49.2
(Method : Urease)			
(Specimen : Serum)			
HbA1c	7.2	%	Normal: <5.7 Prediabetes: 5.7 - 6.4 Diabetes: > 6.5
(Method : HPLC)			
(Specimen : Whole blood)			
 GLUCOSE (RANDOM)	142	mg/dL	80 - 140
(Method : Hexokinase)			
(Specimen : Plasma)			
SEROLOGY			
C.R.P. (C-Reactive Protein)	4.4	mg/L	< 5.0
(Method : Particle-enhanced immunoturbidimetric assay)			
(Specimen : Serum)			



Dr.Monica Kumbhat.,

LAB DIRECTOR

Result Entered By



Tests marked with NABL symbol are accredited by NABL vide Certificate no MC- 5409

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Contact No : 044-35007072 / +91 72990 67800 | email : medwaymedicallabs@gmail.com



94457 94457
1800 572 3003

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Heart Institute | Institute of Pulmonology
044 - 4310 8959 | 044-2473 4451

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