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:

b) Gender: Male ☑ Female Third gender c) Contact no.: 9003064446 d) Alternate contact no.:

e) Age: Years 75 Months f) Date of birth: g) Insurer ID card no.: 507707241886

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: b) Contact no.:

c) Name of Illness/disease with presenting complaints: c/o, acute Lower back pain ? radiation of pain (RT) Lower limb, constant pain of Lower limb

d) Relevant clinical findings:

e) Duration of the present ailment: 1 days e.1) Date of first consultation: 29/01/24

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

f) Provisional diagnosis: ? Lumbar spondylosis c acute (RT) side IVDP - L4-L5 ? L5-S1

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: (tr iv/oral) tab oral

h.1) Route of drug administration: ☑ IV ☑ Oral Other Tr/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: 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 ADMITED

a) Date of admission: 29/01/24 b) Time of admission: 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 p.c

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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. 50000

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:

Doctor's signature:

Date: Time:

UNITED INDIA INSURANCE CO. LTD.,

MA ID	[illegible]
Name	[illegible]
Relation	[illegible]
Primary Member	[illegible]
Entity	Tractors and Farm Equipment Limited
Emp. No.	[illegible]

Medi Assist Serviced by : **MEDI ASSIST INSURANCE TPA PVT LTD**

24 Hour Toll Free Call Centre 1800-425-9449

This card is only for identification purpose and is not an authorisation to proceed with the treatment or a guarantee for payment.

Subject to the terms and conditions of the underlying insurance policy, this is a [illegible] identification card valid at selected hospitals which enable you to avail cashless hospitalisation only on the basis of preauthorisation issued by Medi Assist.

In case preauthorisation is not issued the policy holder / beneficiary will be required to make payments to hospital and submit the claim to Medi Assist for [illegible] reimbursement.

All preauthorisation and/or settlement of claims is subject to the terms and conditions of the relevant policy.

Please note the following

1. This soft copy of Medi Assist Identity card is valid for identification when printed and presented with a valid proof of identity at any Medi Assist Network Hospital.
2. All non admissible expenses incurred have to be paid directly to the hospital by the [illegible].
3. This card is valid only for hospitalization in India.
4. Please take a print out of this e-card, sign it and hand over the same to the hospital authorities, while availing the cashless hospitalisation facility.
5. Along with this card acceptable proof of identity such as ID card issued by the employer / Passport / Driver's License / Ration Card / Voter's ID Card / PAN Card [illegible] presented at the Hospital.

For Claim Forms & Complete List of Network Hospitals, visit the following URL
https://www.mediassist.in

MEDI ASSIST INSURANCE TPA PVT.LTD
[illegible] Floor, Tower D, IBC Knowledge Park, Bannerghatta Road, Bangalore 560 029
Toll Free : 1800-425-9449, Toll Free Fax : 1800-425-9559 , www.mediassist.in

Neuberg

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

Mr. k. Lakshmi 75/M — 23.1.24

Kindly admit for management of LBA

Kindly take MRI Lumbosacral area

Rx (Pyriformis syn) Pyriformis needle

H/o LBA + (R) leg radicular pain × 5 m

to R/o IVDP + N' Root compression

Pyriformis syn (R)

Dr. G.K. KUMAR, MD., DA., FIPP, DHSc (AC)
Fellow of Interventional Pain Practice (WIP-USA)
Pain Physician & Intervention Pain Specialist
Reg No: 50699

THE PAIN CLINIC

An Exclusive Pain Management Center with Advanced Interventional Facilities

No.28, 2nd Floor, 100 Feet Road, Next to Aarthy Mahal, Vadapalani, Chennai - 26
63693 66676 | painclinicdoctor@gmail.com | www.chennaipainclinic.com

" TOWARDS A PAIN FREE WORLD "

☐ Clopidogrel Genotyping ☐ ADA - serum / body fluids
☐ Master Health Checkup ☐ Geriatric health Checkup(MHC+PSA)
For PT & aPTT Please indicate ☐ Pre operative Monitating OAT Monitoring Heparin / LMWH

Signature

(PTO for Health Packages & Profiles)

Chennai,Tamil Nadu 2024.01.24 10:40
By VVK

இந்திய அரசாங்கம்
Government of India

கி லக்ஷ்மி
K Lakshmi
பிறந்த நாள்/DOB: 13/06/1948
பெண்/ FEMALE

6486 6585 5281
VID : 9129 9887 2072 6431

எனது ஆதார், எனது அடையாளம்

Unique Identification Authority of India

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

Address:
C/O Jeleswari Rao, NEW NO 163/1, OLD NO 59, 2ND FLOOR F1, HABIBULLAH ROAD, Thiyagaraya Nagar, Chennai, Tamil Nadu - 600017

QR Code with Photograph

6486 6585 5281
VID : 9129 9887 2072 6431

SAFE

Udaya Bhaskar K

Blood Group : O +ve

Employee No : E9448

Issuing Authority

Holder's Signature

K Udaya Bhaskar

MH/PRINT /0054/ NRS

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 : 4th floor	Room No. : 402
Consultant Dr. : Dr Kumar G K			D.O.~~A~~ : 29/1/24
Temp : 98°F Pulse : 86/mt Resp : 20/m		Allergies : —	
B/P : 130/90 mmHg Height : — Weight : —		Current Medications : —	

Sp02-97%.

0 No Pain | 1 Just noticeable | 2 Mild Pain | 3 Uncomfortable Pain | 4 Annoying Pain | 5 Moderate Pain | 6 Just bearable | 7 Strong Pain | 8 Severe Pain | 9 Horrible Pain | 10 Worst Pain

Complaints

P[L] came to hospital with c/o - 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 (+)

Past history of relevance

family and Personal

- K/C/o - SHTN. on Regular medications

- S/P - Hysterectomy

- S/P - Cholecystectomy

Clinical Examination

O/E: conscious, oriented, afebrile

S/E:

CVS: S_1S_2 (+)

RS: BAE (+)

Continuation on the reverse side ☐

LIE:-

SLR (R) -40°

(L) -70°

- well leg rising test is positive
- Root tension sign are positive

Investigation required

MRI - LS spine to rule out piriformis syndrome

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

Diagnosis

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

Plan of Care

Pt. advised under Dr. G.K. Kumar

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

Signature Elango

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

Examined by Dr. Sri Elango Kannan. P

MC-5409

Medway Labs
(A Unit of United Alliance Healthcare Pvt Ltd)

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 " SECS	Mins	01 - 03
(Method : *)*			
(Specimen : *NA)*			
CLOTTING TIME	" 04 " MINS " 00 " SECS	Mins	03 - 07
(Method : *Capillary method)*			
(Specimen : *NA)*			
HAEMOGLOBIN	11.8	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)	23.4	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

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

@MedwayHospitals @medwayhospitals @medway-hospitals @medwayhospitals
#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
Kodambakkam 044-2473 4455 | Mogappair 044-26530011 | Kumbakonam 044-2473 4455 | Chengalpattu 044-27426829 | Villupuram 04146-242000

Medway Centre of Excellence (Chennai)
Heart Institute 044 - 4310 8959 | Institute of Pulmonology 044-2473 4451

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

MC-5409

Medway Labs
(A Unit of United Alliance Healthcare Pvt Ltd)

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

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