4m

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: **VIDAL HEALTH INSURANCE TPA PRIVATE LTD.**

b. Toll free phone number:

c. Toll free fax:

d. Name of Hospital: **MEDWAY HOSPITALS**

i. Address **# 2/26, 1st MAIN ROAD, UNITED INDIA COLONY, KODAMBAKKAM, CHE-600024**

ii. Rohini id **8900080347533**

iii. e-mail id **MEDWAYINSURANCE@GMAIL.COM**

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : Anima Mahgrang

B. Gender: ☐ Male ☑ Female ☐ Third Gender

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

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

E. Contact number: 93487 56068

F. Contact number of attending Relative:

G. Insured Card ID number: CHE-RS-T/120-002-002306-A

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.T. Palaniappan

B. Contact number: 044-24734455

C. Nature of Illness / Disease with presenting complaint: 4o, fever, vomiting ×2 days (4 episodes), Abdominal pain ×3 days

D. Relevant Critical Findings:

E. Duration of the present ailment: Days loss of appetite ×3days

i. Date of First consultation: 23/01/24 (DD/MM/YYYY)

ii. Past history of present ailment, if any - Nil -

F. Provisional diagnosis: A. Appendicitis

i. ICD 10 code - nil -

G. Proposed line of treatment:

i. Medical Management (✓)
ii. Surgical Management (✓)
ii. Intensive care ( )
iv. Investigation ( )
v. Non-allopathic treatment ( )

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

i. Route of Drug Administration : Oral

I. If surgical, name of surgery Diag: Laparoscopy + (Rt) ovarian cystectomy

i. ICD I0 PCS code

J. If other treatment, provide details - nil -

K. How did injury occur Nil -

L. In case of accident

i. Is it RTA: NA ☐ Yes ☐ No
ii. Date of Injury: (DD/MM/YYYY)
iii. Report 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 report) ☐ Yes ☐ No

M. In case of Maternity ☐ G ☐ P ☐ L ☐ A

i. expected date of Delivery (DD/MM/YYYY)

DETAILS OF PATIENT ADMITTED

A.	Date of admission	23/01/24 (DD/MM/YYYY)
B.	Time of admission	(HH:MM)
C.	Is this an 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. Hypertension	
	iv. Hyperlipidemias	
	v. Osteoarthritis	
	vi. Asthma/COPD/Bronchitis	
	vii. Cancer	
	viii. Alcohol/Drug abuse	
	iX. Any HIV/ or STD Related ailment	
	X.Any other ailment, give details	
E.	Expected number of Days / stay in hospital	4 to 7 Days
F.	Days in ICU	Days
G.	Room Type	Twin Sharing
H.	Per day room rent+nursing and service charges+ patients diet	
I.	Expected cost of investigation + diagnostic	
J.	ICU charges	
K.	OT charges	
L.	Professional fees Surgeon + Anesthetist Fees + consultation Charges	
M.	Medicines + Consumables + Cost of Implants (if applicable please specify)	
N.	Other hospital expenses if any	
O.	All-inclusive package charges if any applicable	
P.	Sum Total expected cost of hospitalization	₹ 2,60,000/- (Approximately)

DECLARATION
(Please read very carefully)

We confirm having read understood and agreed to the Declarations of this form

a.	Name of the treating doctor	Dr. Balaraman
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

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 amount over & above the limit authorized by the Insurer / T.P.A. 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 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 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: Anitha

b) Contact Number: _____ email-Id (optional) _____

c) 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 responsibility the sole 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.

Hospital Seal

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

Doctor's Signature

Date: _____ Time: _____

Royal Sundaram
General Insurance

VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR

Card No CHE-RS-T1120-002-0024306-A
ANITA MAHARANA
Sex : F **Age** 19 Year/s

TVS EDUCATIONAL SOCIETY
Valid From 01-Sep-2023
Emp No L05571

24x7 Helpline 18604250253/080-46267020

This card is non-transferable. It is issued only for identification purposes and not as an authorization to proceed with the treatment or as any guarantee for payment. Use of this card is governed by the policy terms & conditions. This card is valid at hospitals empanelled with Vidal Health Insurance TPA Private Limited. Cashless hospitalisation can be availed of but it is subject to preauthorisation approved by Vidal Health. In case preauthorisation is not approved, the policy holder is required to make payment to the hospital and submit the claims to Vidal Health for a possible reimbursement. For hospitalisation rolls pertaining to non-medical expenses, the policy holder is required to make payment to the hospital directly. This card is to be produced with Pan Card/Passport/Driver's License/Voter's ID card to prove identity of the claimant. This card is valid subject to continued renewal of the policy. Vidal Health Insurance TPA Private Limited is your authorised Third Party Administrator.

For an updated hospital list with local contact details please visit: **www.vidalhealthtpa.com**

VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR

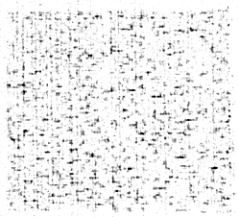
Bengaluru: 080-40125000, **Bhubaneswar:** 0674-2530092, **Chennai:** 044-42064444
Coimbatore: 0422-2491335, **Delhi:** 011 23715781, **Hyderabad:** 040-66001000/01
Kochi: 0484-2358643, **Kolkata:** 033 22884196, **Mumbai:** 022-23214700
Pune: 020-25530398, **Vizag:** 0891-6670197

If found please return to:
Vidal Health Insurance TPA Private Limited
Tower No. 2, First Floor, SJR I Park, EPIP Zone, Whitefield, Bangalore-560 066.
E-mail: help@vidalhealthtpa.com **Website:** www.vidalhealthtpa.com

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

Enrolment No: [illegible]

Anita Maharana
[illegible]



आपका आधार क्रमांक / Your Aadhaar No.

8501 9967 7604

मेरा आधार, मेरी पहचान

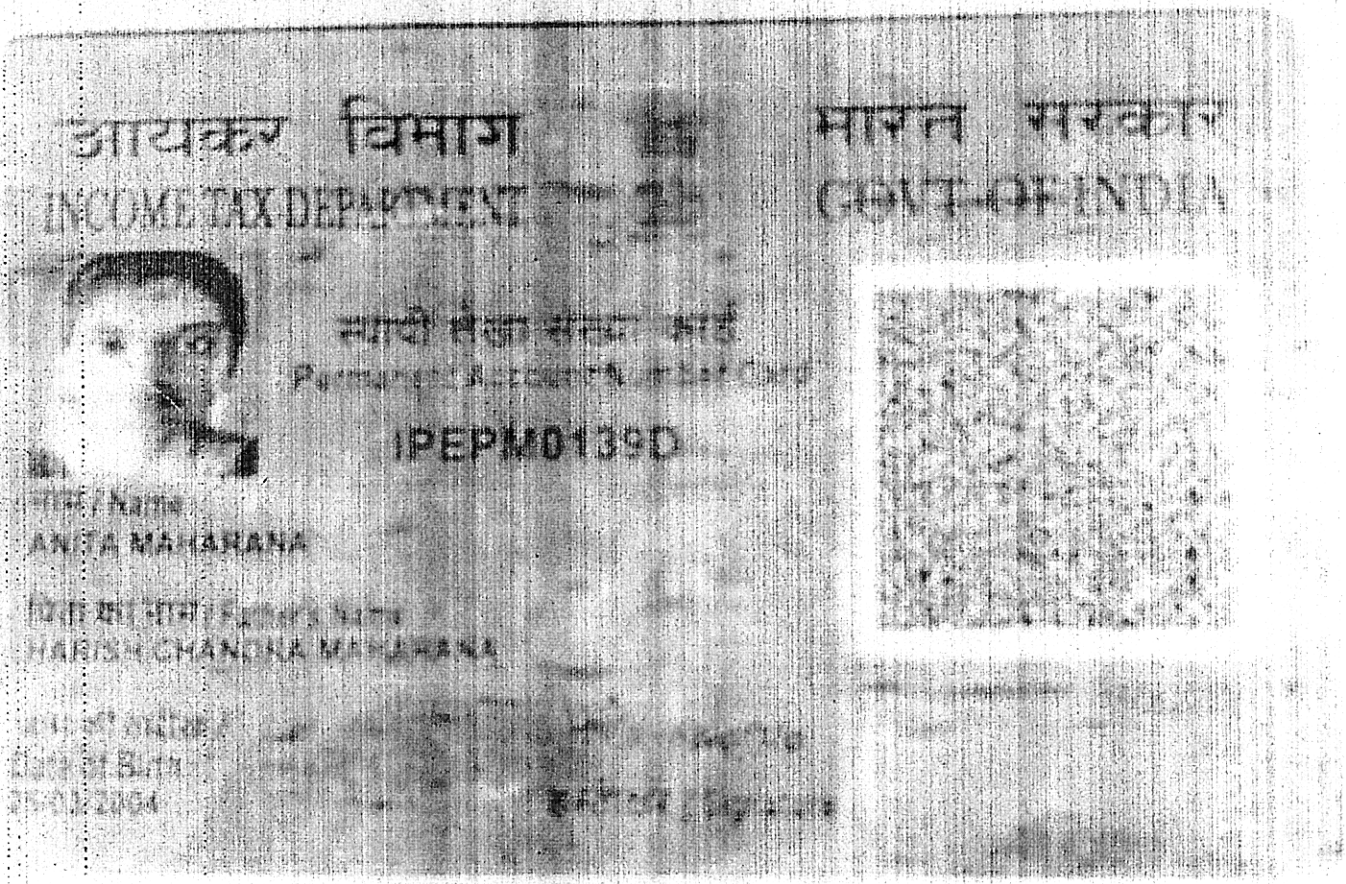
भारत सरकार
Government of India

Anita Maharana
जन्म तिथि / DOB: 15/01/1994
महिला / Female

8501 9967 7604

मेरा आधार, मेरी पहचान

Anita Maharana
Phone No - 9348756068

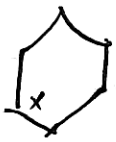

आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT. OF INDIA
IPEPM0139D
ANITA MAHARANA
HARISH CHANDRA MAHARANA

Medway Hospitals®
The way to better health

MS. ANITHA MARUNA 19/F

23.01.24

C/o Abdominal pain
nausea
loss of appetite
3days



RIF tenderness (+)

Dx Appendicitis?

BP 110/60 mm
P 108/min
SpO2 99
T 99°F
LBU - 77 mg/dl

Adv:

1. Admit & to get Abinaya (Gensurgeon) Opinion after CT-Abdomen Report
2. INJ PAN 40mg IV STAT then BD
3. INJ. EMESET 4mg IV STAT then BD
4. INJ. PARACETAMOL IV STAT then BD
5. To do surgical park.

MH/PRINT /0054/ NRS

Medway Hospitals®

The way to better health

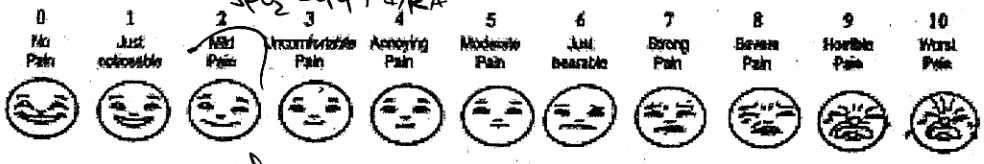
HISTORY & PHYSICAL EXAMINATION FORM

Patient's Name : Mrs. Anitha Nagarajan.		I.P. No.	: 3221
Age : 19.	Sex : M / F.	Ward : 4th Floor	Room No. : 23(A)
Consultant Dr. : DR. T. Palaniappan.		D.O.A.	: 23/1/24

Temp : 99.1 F Pulse : 80 Resp : 20	Allergies : -
B/P : 120/80 Height : - Weight : -	Current Medications : -

SpO2 - 99% RA

CBH-77



Complaints

c/o. Fever x 3 days.
Vomiting x 2 days x 4 episode.
Abdominal pain x 3 days
loss of appetite x 3 days.

History of Present illness

- pt. had these symptoms.
LMP - 26/12/23. three days back for which
she had consulted. Was prescribed
which symptoms doesn't resolve hence
Sought consultation here.

Past family and Personal history of relevance

-

Clinical Examination

o/E - pt. conscious,
oriented,

S/E - CVS - S1 S2 (+)
RS - BAE (+)
PA - Soft,
tenderness (+),
No guarding.

Continuation on the reverse side ☐

Investigation required

Surgical/bark, Serology.,
CT Abdomen.

Diagnosis

- ? Abberdicitis.

Plan of Care

- Inj: pan 40mg I v stat
- Inj: emest 4mg IV stat
- Inj: para 1gm IV stat.
- Plan CT reports, Blood reports
- NPO.

Date : 23/1/24 Time : 8:20pm

Signature

Examined by Dr Sujitha B

Medway Hospitals®
The way to better health

CHENNAI : # 2/26, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024.
Tel : 044 - 2473 4455 | Mobile No : 9962 985 985
KUMBAKONAM : No. 142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai, Ammachathiram (Post),
Thiruvidaimarudhur (Taluk), Kumbakonam - 61 2103. (Taniore Dist). Ph: 0435 - 2412345 | Mob : 7397720491
E-mail : info@medwayhospitals.com I Website : www.medwayhospitals.com

OPERATION THEATRE RECORD

Surgery	: Diagnostic laparoscopy + Appendectomy + (R) ovarian cystectomy	Anaesthesia	: GA
Surgeon	: Dr. Abinaya Srinivasan	Anaesthesiologist	: Dr. Sathish Babu.
Assistant	: S —		
Staff Nurses	: S/N Pavithra/Jamuna		
Date	: 28/1/24		

Under GA patient put in supine position parts painted & draped. Laparoscopic ports inserted - One 12mm & two 5mm in teriangulation.

Intraop findings :-

(1) Long appendix with inflammed tip
(2) Fluid in cul de sac with bilateral polycystic ovaries with large right ovarian cyst with clear fluid
(3) Normal appearance of mesentery, small & large bowel, liver and uterus with bilateral tubes. Loaded large bowel loops.

Right ovarian cystectomy. Appendicular base secured with loops (two) and stump amputated.

Continuation on the reverse side ☐

POST OPERATIVE INSTRUCTIONS

Thorough wash given.
Port sites closed in layers.
Pt extubated on table.

Postop orders

① NPO for 6hrs & then liquids & soft solids
② IV cefol-S complete 5 days & stop
③ Continue other medications
④ Ambulate.

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DRUG CHART

MH/ PRINT / 0042

Name of the Patient : Ms. Anitha Maharana Age 19ys Sex F Bed No. E2-B

Clinical Diagnosis : IP No. 0169 Ht. Wt.

Primary Consultant Name : Dr. T. Palaniappan PID No. 3221

Name of the Medicine	Dose	Route	Frequency	30/1/24																											
INJ. PAN	40mg	IV	1-0-1	9 am		9pm																									
T. SIGNOFLAM	1tab	PO	1-0-1	9 am		9pm																									
C. BIFILAC	1CAP	PO	0-1-0		9pm																										
INJ. BUSCOPAN	1amp	IV	SOS																												
INJ. PARA	1gm	IV	SOS	D6																											
INJ. CEFOL S	1.5gm	IV	1-0-1	9 am		9pm	I stop																								
SYP. DUPHLAC	30ml	PO	0-0-1			NK																									
Administered by (Nurse Signature) : 183161				[signature]		[signature]																									
Verified by (DMO Signature) :																															

Nurse Signature : [signature] 23580

Nurse Name : S/N Vennila

Date & Time : 30/1/24 at 6.30 AM.

DMO Signature : 183161

DMO Name : Peer Mohamed Farhan

Date & Time : 30/1/24 + 6:30 Am

Primary Consultant Signature : for D

Primary Consultant Name : Dr. T. Palaniappan

Date & Time : 30/1/24 @ 6:30 Am

Reg No. : 55530

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

PATIENT NAME:	Ms.ANITHA MAHARANA	AGE/GENDER :	19YRS/FEMALE
PATIENT ID :	MMH-202473221	DATE :	23.01.2024

G.I TRACT: The stomach is normal in site and size. The duodenum and proximal jejunal loops are normal in caliber. The ileum and ileo–caecal junction are normal. **Large bowel loops appear loaded with faecal matter.**

Appendix measures 5.5 mm in maximum diameter and is seen in retrocaecal position. No evidence of periappendiceal fat stranding.

Few small volume right iliac fossa mesenteric lymph nodes are noted, largest measures approximately 6 mm in short axis diameter.

URINARY BLADDER shows normal wall thickness. No evidence of intraluminal pathology

The aorta and IVC appear normal.

UTERUS AND BILATERAL ADNEXAE APPEAR NORMAL

IMPRESSION:

LEFT RENAL CALCULUS.

FEW SMALL VOLUME RIGHT ILIAC FOSSA MESENTERIC LYMPH NODES.

FAECAL LOADED LARGE BOWEL LOOPS - ? CONSTIPATION.

(Kindly correlate clinically)

DR.CHRIS JOSEPH
M.D (RD)
Consultant Radiologist

PATIENT NAME:	Ms.ANITHA MAHARANA	AGE/GENDER :	19YRS/FEMALE
PATIENT ID :	MMH-202473221	DATE :	23.01.2024
REFD DR :	DR.T.PALANIAPPAN.,	MODALITY :	CT
		ACC NO :	CT-2501,52503

CT SCAN - ABDOMEN (PLAIN AND CONTRAST) REPORT

serial axial sections of the Abdomen were studied with& without administration of oral & I.V. contrast and the following observations are made.

LIVER: Normal in size with normal density noted. The porta hepatis is normal. The intrahepatic portal venous radicals are normal. No evidence of intrahepatic billiary radicular dilatation. The hepatic veins and intrahepatic portion of inferior venacava are normal.

GALL BLADDER .is partially distended

SPLEEN: Normal in size, shape and attenuation values. The splenic hilum and splenic vein are normal.

PANCREAS: Normal in size, contour and attenuations values. No evidence of focal mass lesion/pancreatic duct dilatation.

ADRENAL GLANDS: Normal in size, shape and attenuations values.

KIDNEYS:

RIGHT KIDNEY is normal in size and shape. The renal outlines are normal. No evidence of focal mass lesion/hydronephrosis/ calculi.

LEFT KIDNEY is normal in size and shape. **Radiodense calculus of size 3 mm noted in the upper pole calyx.**