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

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: [illegible] MALAR HOSPITALS

Hospital location: [illegible] No. 2 Old No. 29, 1st Main [illegible] Hospital ID: [illegible]

Hospital email ID: [illegible] United Indian Corp [illegible] ROHINI ID: [illegible]

Kodambakkam, Chennai-

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: Mythili

b) Gender: ☐ Male ☑ Female ☐ Third gender c) Contact no.: 9944030523 d) Alternate contact no.:

e) Age: Years 73 Months ☐☐ f) Date of birth: ☐☐/☐☐/☐☐☐☐ g) Insurer ID card no.: 40408583 19

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: Dr [illegible] 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: Dr [illegible] b) Contact no.:

c) Name of Illness/disease with presenting complaints:

40, B/L, Pedal Edema,
40, cough & Expectoration (+)

d) Relevant clinical findings:

e) Duration of the present ailment: 3 days e.1) Date of first consultation: 30/01/24.

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

f) Provisional diagnosis:

B/L, Pedal Edema & exacerbation

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

I/V/od

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 NA n) Expected date of delivery: ☐☐/☐☐/☐☐☐☐

DETAILS OF THE PATIENT ADMITED

a) Date of admission: 30/01/24 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: Elite Maternity ofc

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY
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TO BE FILLED IN BLOCK LETTERS

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. 90000/-

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:

nil

DECLARATION (PLEASE READ VERY CAREFULLY)

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

a) Name of the treating doctor: Dr. Shiva Kumar

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: Mythili

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: SUNDAY HOSPITALS No. 2, Old No. 26, 1st Main Road, United India Colony

Doctor's signature:

Date: Time:

MH/PRINT /0054/ NRS

Medway Hospitals®

The way to better health

HISTORY & PHYSICAL EXAMINATION FORM

Mrs.MYTHIL SETHURAMAN
73/Female/MH202473420
30/01/2024/II 2024000230
Dr.SHIVA KUMAR D

Patient's Name : Mrs Mythil Sethuraman I.P. No. : 0230

Age : 73 Sex : M / F Ward : 3rd Room No. : ES-A

Consultant Dr. : Dr. Shiva Kumar. D.O.R. : 30/1/24

Temp : 98.4 Pulse : 90/mt Resp : 22 Allergies : — Nil

B/P : 120/80 Height : ± 160 Weight : ± 68 kg Current Medications : Yes —

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

C/o B/L Pedal Edema

C/o Cough & Expectoration (+)

History of Present illness

Pt. presented W/o of B/L Pedal edema Non pitting & decreased x 3 days

C/o Cough & Expectoration (+)

C/o Sleep Disturbance (+)

Past history of relevance

family and Personal

No H/o Fever / Abd pain

No H/o vomiting / Loose stools

Clinical Examination

K/C/O T2DM / HTN on Tx / Dyslipidemia

S/P Hysterectomy @ 21/1/24

P3L3 SNVD / S/P Hysterectomy /

Family H/O NAD significant

Pt. Conscious

oriented

Afebrile

CVS - S1 S2 (+)

Continuation on the reverse side ☐

K/C/O HTN DM

B/L wheeze ↓

PA-soft

CVS-WNL

Yk-Dk Pedal edema (+)

Investigation required

CBC, RFT, LFT, Electrolytes, RBS

ECG, D-Dimer,

CXRay PA view

Diagnosis

B/L Pedal Edema ↓ Evaluation

T2DM / Stage 1 Dyslipidemia

Plan of Care

Inj. Emeset 4mg IV stat

Inj. Pantop 40mg IV BD

Inj. Lasix 40mg IV stat

Inj. Heparin 5000units SC BD

Inj. Dr. Shanthmar SIV

Signature .....

Date : 31/1/24 Time : 12.30 p.m. Examined by ..... DR. SAMHSON

THE NEW INDIA ASSURANCE CO. LTD.

Wholly owned by Government of India

Insurance Cashless e-Card

Employee Name	Ravikumar Sethuraman	Policy Holder	Tata Consultancy Services Ltd
Employee ID	246513		
Policy Start Date	01-Apr-2023	Policy End Date	31-Mar-2024
Room Eligibility 1	Entry Level Single AC Private Room for Employee/Spouse/Child		
Room Eligibility 2	Twin Sharing AC Room for Parent/Parent-in-law		

Beneficiary name	Medi Assist ID	DOB	Relation
Ravikumar Sethuraman	4040809098	23-Apr-1975	Self
Gargee Ravikumar	4040809099	27-Dec-1982	Spouse
Shashwat	4040809100	18-May-2005	First Child
Mother	4040858319	21-May-1950	Mother
Sankaranarayanan Sethuraman	4040858320	08-Aug-1944	Mother-in-law

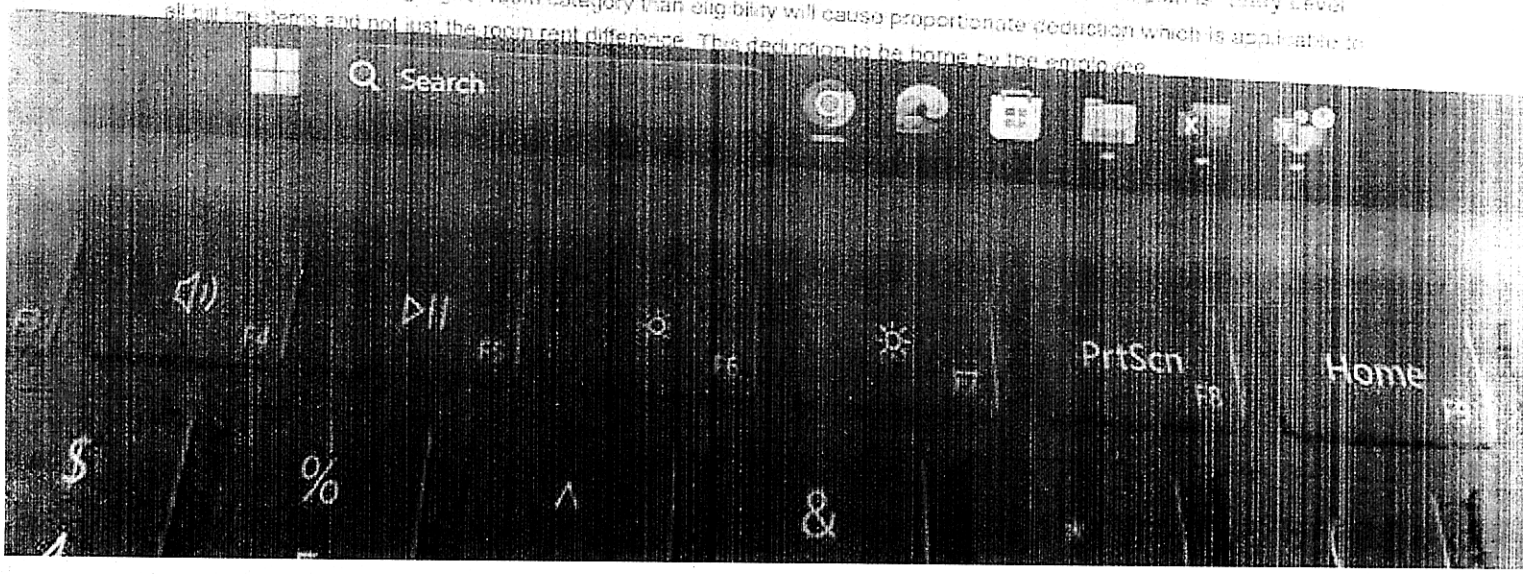
HELPLINE NUMBERS:

24 hours helpline : 040-68213610

- This card is only for identification and is not an authorization to proceed with the treatment or a guarantee for payment
- In the case of photoless identity cards issued to beneficiaries, acceptable proof of identity such as Aadhar Card/Passport/Driver License/ Ration Card / Voters ID Card / PAN Card should be presented at hospitals
- This non-transferable identification card is valid at selected Network Hospitals & will enable Card Holder to avail cashless hospitalization only on the basis of preauthorization by Medi Assist
- For the latest updated hospital list, login to www.medi-assist.com

Important Notes:

- Room Rent Eligibility for parents and parent in law for all plan except Platinum Plus and Platinum plan is "Entry Level Twin Sharing AC". Opting higher room category than eligibility will cause proportionate deduction which is applicable to all hospitalization and not just the room rent difference. This deduction to be borne by the employee



TCS/...

Date...

TO WHOMESOEVER IT MAY CONCERN

This letter is to certify that **Mr. Ravikumar Sethuraman** is covered under the TCS Corporate Health Insurance p... The New India Assurance Co. Ltd.

The Corporate policy is registered under Tata Consultancy Services Limited and extended to Mr. Ravikumar Se... 246513)

Insurance Company : The New India Assurance Co. Ltd

Policy Holder Name : Tata Consultancy Services Ltd

Policy Number : 920000342304000000001

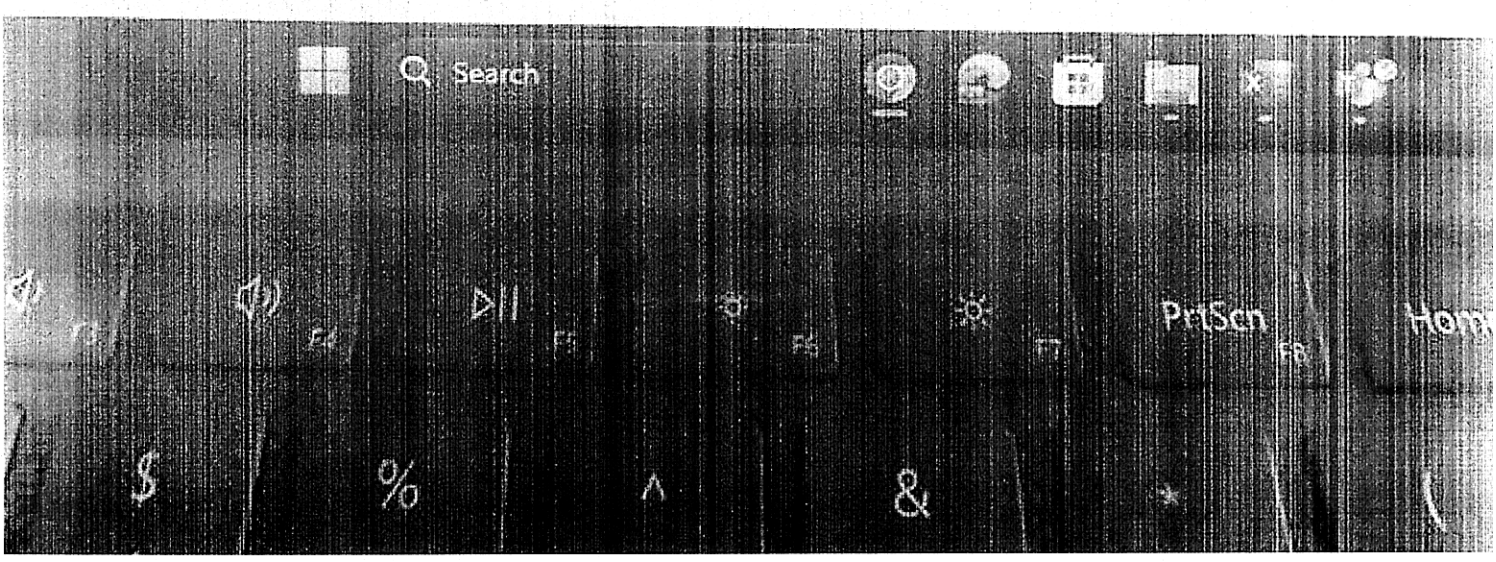
Mr. Ravikumar Sethuraman has covered the following beneficiaries under TCS India health ins...rance Scheme

Sr No.	Name	Relationship	Date of Birth	Coverage Start Date	Policy Deactivation	D... No.
1	Ravikumar Sethuraman	Self	23-Apr-1975	01-Apr-2022	--	31-...
2	Bargavi Ravikumar	Spouse	27-Dec-1982	01-Apr-2022	--	31-...
3	Bharadhwaj	First Child	18-May-2006	01-Apr-2022	--	31-...
4	Mythili	Mother	21-May-1950	01-Apr-2022	--	31-...
5	Saraswathi Srinivasan	Mother-in-law	08-Aug-1944	01-Apr-2022	--	31-...

This letter is issued upon request to enable the associate to avail a retail policy as per its terms and conditions

Policy deactivation date or date of relieving (DOR) mentioned in this letter is based on the assignment sta... associate as on date of issue of this letter and is subject to change

***** This is a system generated certificate which requires no signature *****



भारत सरकार
Government of India

Issue Date : 15/12/2011

சேதுராமன் மைதிலி
Sethuraman Mythili
பிறந்த நாள் / DOB : 21/05/1950
பெண் / Female

आधार पहचान का प्रमाण है, नागरिकता का नहीं।
Aadhaar is a proof of identity, not of citizenship

6593 4143 1663

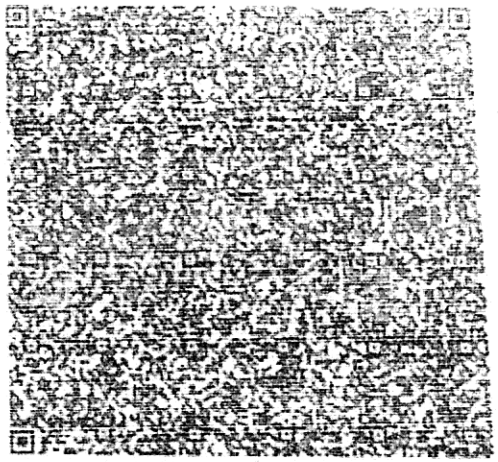
मेरा आधार, मेरी पहचान

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

முகவரி: W/O கே வி சேதுராமன்,
பு.எண்.18, ப.எண்.22 சக்தி நகர்,
கோடம்பாக்கம், சென்னை, தமிழ் நாடு,
600024

Print Date : 25/05/2023

Address: W/O K V Sethuraman, new no.18, old no.22, Sakthi Nagar, Kodambakkam S.O, Chennai, Tamil Nadu, 600024



6593 4143 1663

1947 help@uidai.gov.in www.uidai.gov.in

S Ravikumar

பிறந்தவருடம் / Year of Birth : 1978

ஆண்பால் / Male

7605 2328 6334

ஆதார் - சாதாரண மனிதனின் அதிகாரம்

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

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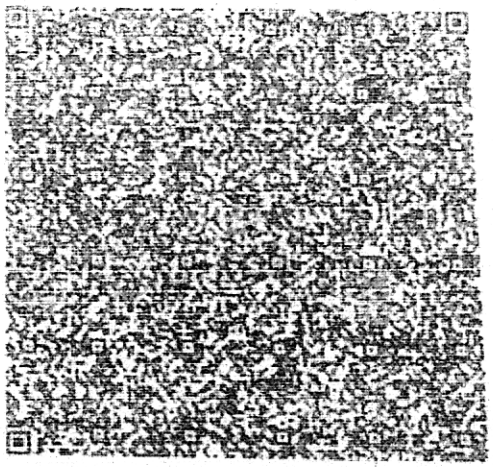
கோடம்பாக்கம், சென்னை, தமிழ் நாடு,
600024

Print Date : 25/05/2023

Address: W/O K.V Sethuraman, new no.18, old no.22, Sakthi Nagar, Kodambakkam S.O, Chennai, Tamil Nadu, 600024



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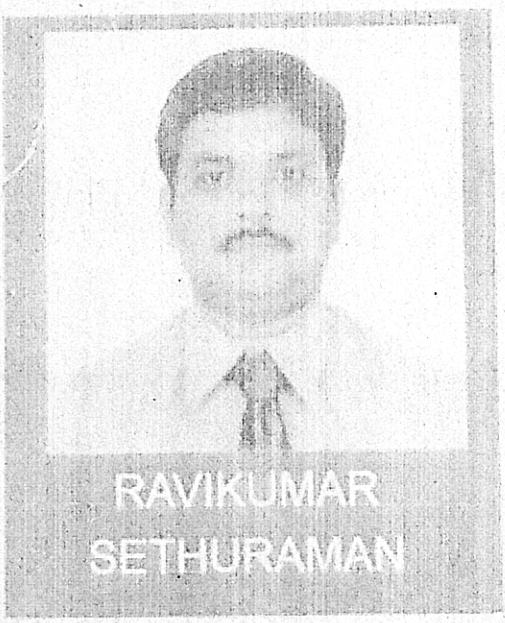
1947 help@uidai.gov.in www.uidai.gov.in

TATA

TATA CONSULTANCY SERVICES



RAVIKUMAR
SETHURAMAN

Card No : 181505

Associate : 246513

Tata Consultancy Services Ltd
379 Thornall Street 4th & 11th Floor
Edison NJ-08837

INCOME TAX DEPARTMENT

GOVT. OF INDIA

S RAVIKUMAR

SETHURAMAN

23/04/1975

Permanent Account Number

AXKPS9777R

S. Ravi

MH/PRINT /0064/ NRS

Medway Hospitals®
The way to better health

I P INSTRUCTION AND MONITORING CHART

Mrs.MYTHIL SETHURAMAN
73/Female/MM H202473420
30/01/2024/II 2024000230
Dr.SHIVA KUMAR D

ioom No.
ir. Name
lame

ate	30/1	31/1/24						
R / BP	Day / Night	Day / Night	Day / Night	Day / Night	Day / Night	Day / Night	Day / Night	Day
	12, 4, 8, 12, 4, 8	6, 8, 12, 4, 6, 8						Temp.
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								104°
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Medway Hospitals ®
The way to better health

DRUG CHART

Name of the Patient : Mythili Sethuraman. Age 73 Sex F Bed No. ESA

Clinical Diagnosis : Q IP No. 3H20 Ht. 160 Wt. 65

Primary Consultant Name : Dr. Shivakumar PID No. 0230

Name of the Medicine	Dose	Route	Frequency	31/1/24		
INJ. EMESET	4mg	IV	1-1-1	8 AM	2 PM	8 PM
INJ. RANTAC	50mg	IV	1-0-1	8 AM		8 PM
INJ. HEPARIN	5000 IU	S/C	1-0-1	8 AM		8 PM
TAB. AZTOR	10mg	P/O	0-0-1			8 PM
TAB. CETANIC	10mg	P/O	1-0-0	8 AM		
TAB. METOCARD XL	25 mg	P/O	0-0-1			8 PM
~~TAB. ASCOR~~						
Administered by (Nurse Signature) :				IN		
Verified by (DMO Signature) :						

Nurse Signature : [signature]
Nurse Name : Reshma
Date & Time : 30/1/24 @ 12am

DMO Signature : [signature]
DMO Name : Peer Mohamed Kader
Date & Time : 30/1/24 @ 12am

Primary Consultant Signature : [signature]
Primary Consultant Name : Dr. Shiva Kumar
Date & Time : 30/1/24 @ 12 Am
Reg No. :

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The way to better health

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS				
31/1/2	2am	INJ. LASIX	40mg	IV	Dr. Farhan					
	2am	Inj - Pantac	40m	IV	Dr Shivaraj	2061				
	2am	Inj - Emeset	4mg	IV	Dr Shivaraj mar					
	1am	3% NaCl	100ml	IV	Dr Shivaraj					

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS				