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

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: Medicity Hospital
Hospital location: Chandapura
Hospital ID:
Hospital email ID: cgiicu@medicityhospital.com
IRDAI 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: MRS. EMMA JOSEPH WESLEY
b) Gender: [ ] Male [✓] Female [ ] Third gender
c) Contact no.: 9986044118
d) Alternate contact no.:
e) Age: Years [ ] Months [ ]
f) Date of birth:
g) Insurer ID card no: 403802329 6
h) Relation/Name of corporate: Wesley Jebadoss Jayakumar
i) Employee ID: I34544
j) Currently do you have any other medical claim, health insurance: [ ] Yes [✓] No
j.1) Insurer name:
Give details: -
k) Do you have a family physician, if yes: Name:
k.1) Contact no.:
l) Occupation of insured patient: Retired
m) Address of insured patient: Enclosed.

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor: DR. ARAVINDHA RAO
b) Contact no.:
c) Nature of illness/disease with presenting complaints: c/o High grade fever x 4 days
d) Relevant clinical findings:
e) Duration of the present ailment: days
e.1) Date of first consultation: 02/02/24
f) Past history of present ailment if any:
g) Provisional diagnosis: LRI
g.1) ICD 10 code:
h) Proposed line of treatment: [✓] Medical management [ ] Surgical management [ ] Intensive care [ ] Investigation [ ] Non Allopathic treatment
i) If surgical or medical management, provide details: Enclosed
h.1) Route of drug administration: [ ] IV [ ] Oral [ ] Other: IV/IM/DRIP
j) If Surgical name of surgery: -
j.1) ICD 10 PCS code:
j) If other treatments provide details:
k) How did injury occur:
i) 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:

DETAILS OF THE PATIENT ADMITTED

a) Date of admission: 02/02/24 b) Time of admission: c) This is [✓] an emergency/ [ ] a planned hospitalization event
d) Expected no. of days stay in hospital: 3 Days e) Days in ICU: Days f) Room type: Single room

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

PART C (Revised)

TO BE FILLED IN BLOCK LETTER

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. 25000/-

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: DR. Aravinda Reddy

c) Registration No. with State code:

b) Qualification:

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: M. Wesley

b) Contact number: 9986044140

c) Email ID: (Optional)

d) Patient's / Insured's signature: [signature]

Date: 03072024

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: Medway JSP Hospitals ... Road [stamp, signature]

Doctor's signature:

Date:

Time:

The New India Assurance Co. Ltd.

Microchip

Beneficiary name: Fiona Jolene Wesley
Member ID: 4038023246
Employee code: I34849
Relation: Daughter
Date of birth: 16 Mar 2015
Primary insured: Wesley Jebadoss Jeyakumar
Valid upto: 31 Dec 2024
Policy holder: Microchip Technology (India) Private Ltd
Insurer ID: --

MA4038023246

Contact number: 08046855354 18004191172(Backup)

आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT. OF INDIA

WESLEY JEBADOSS JEYAKUMAR

JEYAKUMAR JESUDASAN

26/03/1984
Permanent Account Number
AHTPJ5645G

Signature

24022015

Enrolment No.: 0000/00524/04049

To
Wesley Jebadoss Jeyakumar
S/O Jeyakumar
M B 3-204, Astro Maison Douce,
38/2, Doddakannalli,
Varthur Hobli,
Radha Reddy Layout Road,
Doddakannalli
Carmelaram
Bengaluru Karnataka - 560035
9986044110

Download Date: 09/03/2018

Generation Date: 09/03/2018

Valid Aadhaar

நிமது ஆதார் எண் / Your Aadhaar No. :

6339 4486 7182

VID : 9158 7990 1377 5877

ನನ್ನ ಆಧಾರ್, ನನ್ನ ಗುರುತು

ಭಾರತ ಸರ್ಕಾರ
Government of India

Wesley Jebadoss Jeyakumar
DOB: 26/03/1984
MALE

6339 4486 7182

VID: 9158 7990 1377 5877

ನನ್ನ ಆಧಾರ್, ನನ್ನ ಗುರುತು

Enrolment No.: 2720/10824/14303

To
பி:ஃபோனா ஜோலின் வெஸ்லி
Fiona Jolene Wesley
C/O: Wesley Jebadoss,
M B 3-204 ASTRO MAISON DOUCE, 38/2 RADHA
REDDY LAYOUT ROAD,
VARTHUR HOBLI, DODDAKANNALLI,
VTC: Carmelram,
PO: Carmelaram,
Sub District: Bangalore South, District: Bengaluru,
State: Karnataka,
PIN Code: 560035,
Mobile: 9986044110

66243493

MF662434935FI

உங்கள் ஆதார் எண் / Your Aadhaar No. :

3556 8446 1673

எனது ஆதார், எனது அடையாளம்

இந்திய அரசாங்கம்
Government of India

ஆதார்

பி:ஃபோனா ஜோலின் வெஸ்லி
Fiona Jolene Wesley
பிறந்த நாள் / DOB : 16/03/2015
பெண்பால் / Female

Issue Date : 14/03/2021

3556 8446 1673

எனது ஆதார், எனது அடையாளம்

Midway JSP Hospitals®
The way to better health

CASH SHEET

NAME: Fiona. AGE: 9 y SEX: f

OCCUPATION: Nil BED NO: 57

ADDRESS: 20/65 2nd cross St: varadaraja Nagar Chengalpattu

I.P. NO.: 0162/24

D.O.A.: 02/01/24 TIME: 13:00pm

D.O.D.: TIME:

PHONE/MOBILE: 9986044110

REF. Dr. Dr: Aravindh Raja (peads)

ADVANCE		DUES	
DATE	AMOUNT	DATE	AMOUNT
02/1/24	5.000/-		
TOTAL			

CONSULTANTS

Dr. Aravindh

INVESTIGATIONS

ANY SPECIAL PROCEDURES

Wt: 28.8kg

1.

2.

3.

SL. NO.	BED ALLOTMENT	PLACE & NUMBER	TRANSFER IN	DATE & TIME	TRANSFER OUT	DATE & TIME
1.						
2.						
3.						

CLINICAL EXAMINATION NOTES

2-1-24

S/B Dr. Aravindh.

c/o fever 4 days, high grade since 2 days.

→ c/o cough & cold (+).

→ c/o vomiting (+)

→ c/o loose stools (+).

O/E - Febrile | RR - (N).

SpO2 - (N).

No rashes | No icterus

RS - B/L crepts (+)

D-LRI

(R) > (L).

S/E - NAD.

wt - 28.3 kg.

Im

TC - 141 lw cells.

N - 72%.

Hb - 13.8 g%.

Plt - (N)

CXR - +ve (Unilat)

CXR - ↑ BVM (+).

To do - Widal.

℞

Neb c̄ Duolin (dil)
(+)
Budecort (dil)
1-0-1.

→ Inj. Ceftriaxone 1.25g | IV | 1-0-1.

(DNS) → IVF @ 60 µl/min.

→ Inj. Emeset 2cc | IV | 1-0-1.

→ T. Dolo 650 1/2 tab | po | 1-1-1-1

→ Syp. Prolyte-15 5ml 0-0-5ml

→ T. L-montus kid 0-0-1

→ Syp. Reimfall 5ml 0-0-0.

Medway J[illegible]
The way to [illegible]
(A Unit of United [illegible]
No.70, Kanchipuram [illegible]
Phone : 274[illegible]

(1)

ADDITIONAL CASE SHEET

NAME : Fiona wesley BED No. : 57 IP. No. : 0008/23

DATE & TIME	CLINICAL NOTES	INVESTIGATION	TREATMENT
2-1-24 6.15 pm.		I/B Dr. Aravindh.	
		↑40 fever (+).	
		↑40 cough (+)	
		↓NO vomiting.	
		O/E - Febrile (T-103°F).	
		RR - (N)	
		RS - B/L crepts (+).	
			Adv
			- Continue same Rx.
			↑T. Zerdy 250
			0 - 0 - 1
			↑IV Para 500mg (30mg)
			Stat.
Widal - 1:80 titre			
R/			

2.1.24

3:30PM.

c/s/B - Dr. M. Mohamed Feil (DMO)

A/c/O - LRI

T - 103°F
PR - 112/min
SpO_2 ~99% RA
RR - 24/min

o/e child alert
active
febrile.

Rx

continue the same

s/e CVS - S_1S_2 (+)
RS - B/LAE (+)
B/L crepts (+)
P/A - soft
CNS - NFND

Child.FIONA WESLEY
B/Female/MHC2024000162
02/01/2024/IPC2024000008
Dr ARAVINDH RAJHA P B(PAEDITRIC

Medway JSP Hospitals
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)

GRAPHI T

Name Mrs. Fiona wesley Age 9y MRD No. 0008/22

DATE			02.01.24	3.1.24
No. of DAYS			(1)	(2)
DAYS POST OP.				
TIME			6 10 2 6 10 2	6 10 2 6 10 2
PULSE	°C	°F		
210	340	41.1	106	
200	320	40.6	105	
190	300	40.0	104	
180	280	39.4	103	
170	260	38.9	102	
160	240	38.3	101	
150	220	37.8	100	
140	200	37.2	99	
130	180	36.7	98	
120	160	36.1	97	
110	140	35.6	96	
100	120	35.0	95	
90	100	RESP	60	
80	80		50	
70	60		40	
60	40		30	
50	20		20	
40	B.R.O		10	
STOOLS				
URINE			voided	Nil
SPUTUM			—	—
WEIGHT			28.3 kg	28.8kg
BATH			given	

Child.FIONA WESLEY
8/Female/MHC202400162
02/01/2024/IPC2024000008
Dr.ARAVINDH RAJHA P.S(PAEDITRIC

Medway JSP Hospitals
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)
0, Kanchipuram High Road, Chengalpattu - 2.
Phone : 2742 6829, 2742 8851

D.O.A. : 02.01.24
D.O.D. :
Consultants(s) : Dr. Aravind Rajalpaul

NAME : Child. Fiona wesley
I.P. No. : 0008/24 Age : 9y Sex : F

TREATMENT CHART

S.No.	Drug Name	Strength Mg.	Frequency Route	02/01/24 M	A	N	3/1/24 M	A	N	Any Special Instruction
1.	INJ. XONE (ATD)	1:250mg	IV BD	(1)	12pm	10pm			(2)	
02.	INJ. EMESET	2CC	IV BD		2pm	10pm				
03.	SYRP. Procef-LS	5ML	P/O BD		2PM					
04.	SYRP. RENINSTALL	5ML	P/O 1-0-0 TDS		2PM					
05.	NEB. DUOLIN + BUDECORT	2CC	P/N BD		2PM	10PM				
06.	TAB. L. MONTOUSKD	1	P/O HS							
07.	INJ. PARA	30ML	IV (SOS)			6PM				
08.	TAB. ZADY	250MG	P/O HS	(1)					(2)	
9.	TAB. DOLO 650MG	½ tab	P/O QID							

Laboratory Test Result

Patient Name	: **ChildFIONA WESLEY**	Patient Id	: MHC202400162
Visit No	: IPC2024000008	Sample ID	: CMSer14713
Age	: 8	Order Date	: 02/01/2024
Gender	: Female	Collection Date & Time	: 02/01/2024 5:00:41PM
Visit Type	: IP	Receiving Date & Time	: 02/01/2024 5:01:03PM
Patient Ph No	: 9986044110	Report Date & Time	: 02/01/2024 5:03:56PM
Ward/Bed	: SINGLE ROOM (A/C) / 57	Doctor Name	: Dr.ARAVINDH RAJHA P.S(PAE

Investigation	Value	Unit	Biological Reference Value
SEROLOGY			
WIDAL SLIDE			
S. Typhi ' O '	1:80 DILUTION POSITIVE		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Typhi ' H '	1:80 DILUTION POSITIVE		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Para Typhi 'A (H)'	1:20 DILUTION NEGATIVE		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Para Typhi 'B (H)'	1:20 DILUTION NEGATIVE		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			

----- End of the Report -----

Dr.Monica Kumbhat.,
LAB DIRECTOR

ROSHINI
Result Entered By

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

LABORATORY TEST RESULT

Patient Name	:	Child. FIONA	Bill No.	:	LCRC03665
Age / Sex	:	8-Years / Female	Sample Date	:	31/12/2023 - __:__
Patient ID	:	MH2365954	Report Date	:	31/12/2023 - 12:56:PM
OP Lab No.	:	INVAC15525	Page	:	Page 1 of 2
Referral	:	Dr.ARIVOLI(CHEST PHY) MBBS CHEST PHYSICIAN			

Test Name	Result	Reference Value	Units
HAEMATOLOGY			
CBC			
HAEMOGLOBIN	13.8	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
ESR	28	"Male: 5 -15 Female : 5 - 20	mm
CBC			
TRBC	5.2	Male : 4.6 - 6.1 Female : 3.9 - 5.2	Millions/cumm
HAEMATOCRIT	41.4	39-52	%
TWBC	14100	4000 - 10000	Cells/Cumm
DIFFERENTIAL COUNT			
POLYMORPHS	72	40-70	%
LYMPHOCYTES	26	20 - 40	%
EOSINOPHILS	02	0 - 6	%
MONOCYTES	00	0 - 6	%
BASOPHILS	00	0 - 2	%

Dr.M.Monica Kumbhat.,
MBBS.,M.D.,FGIL
Consultant Pathologist

LAB HOD

Continue..

LABORATORY TEST RESULT

Patient Name	: Child. FIONA	Bill No.	: LCRC03665
Age / Sex	: 8-Years / Female	Sample Date	: 31/12/2023 - __:__
Patient ID	: MH2365954	Report Date	: 31/12/2023 - 12:56:PM
OP Lab No.	: INVAC15525	Page	: Page 2 of 2
Referral	: Dr.ARIVOLI(CHEST PHY) MBBS CHEST PHYSICIAN		

Test Name	Result	Reference Value	Units
MCV	78.7	80 - 100	fl
MCH	25.9	27 - 32	pg
MCHC	33.3	31 - 36	%
PLATELET	2.05	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Lakhs/cumm
ABSOLUTE EOSINOPHIL COUNT	290	40 - 440	Cells/Cumm
BIOCHEMISTRY			
C.R.P. (C-Reactive Protein) slide	POSITIVE 48		Number
SEROLOGY			
A.S.O. TITRE	NEGATIVE	Negative: < 200	IU/ml

Dr.M.Monica Kumbhat.,
MBBS.,M.D.,FGIL
Consultant Pathologist
LAB HOD

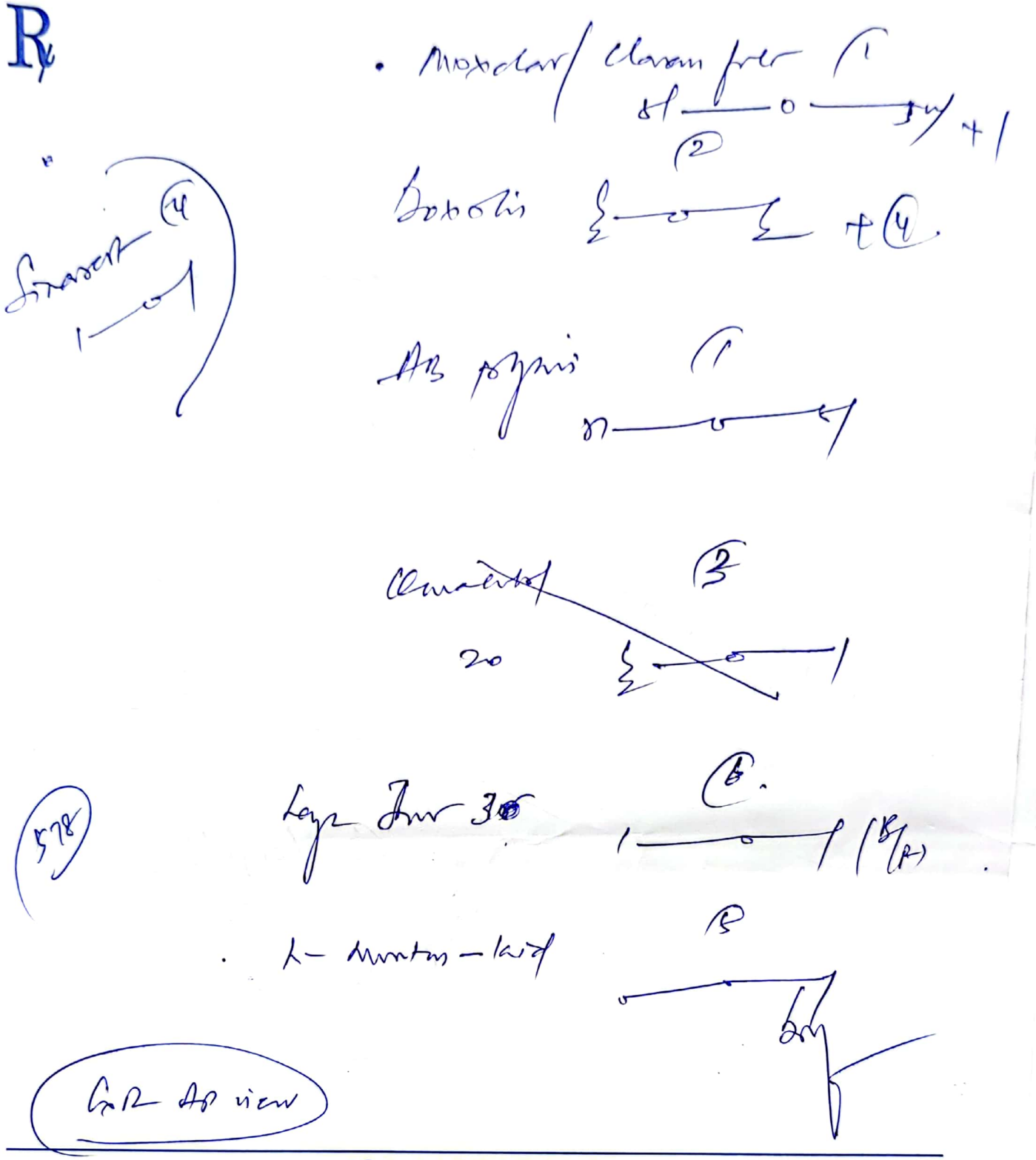
GEETHA.LA
Printed by

Medway JSP Hospitals
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)
No.70, Kanchipuram High Road, Chengalpattu - 603 002. (TN)
Phone : 2742 6829, 2742 8851

Dr. K. ARIVOLI, M.D., (PED), DTCD.,
CHEST SPECIALIST
Reg No : 57219

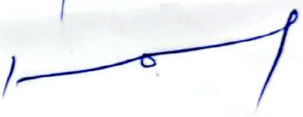
Name : Ms. Fiona Age..... Sex..... Date : 31/12/2023

℞



JSP MEDICALS
CARING BEYOND PRESCRIPTIONS
A UNIT OF JSP HOSPITALS (P) LTD

Brufree (6)



✓ Fluvir (5)

or

Amox / ivantibiotics

CBC / CRP / ASO

S. Ige. / ESR / Ab. E. Cult

N.S. Study