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:

i. Address — Medway JSP Hospitals, No: 70, Kancheepuram High Road, Chengalpattu - 603 002

ii. Rohini id

iii. e-mail id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : GNANAPRAKASH

B. Gender: [✓] Male [ ] Female [ ] Third Gender

C. Age: / 28 (Years) / (Month)

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

E. Contact number: 8667845135

F. Contact number of attending Relative:

G. Insured Card ID number: CHE-NI-T1090-001-0001437-A

H. Policy number / Name of Corporate: TPI /

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:

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 ~~ARTHR~~

B. Contact number: 27426828

C. Nature of Illness / Disease with presenting complaint: c/o fever and cough x 5 days

D. Relevant Critical Findings:

E. Duration of the present ailment: Days

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

ii. Past history of present ailment, if any

F Provisional diagnosis: Acute Febrile Illness

i. ICD 10 code

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

i. Route of Drug Administration : Drug chart Enclosed

I. If surgical, name of surgery

i. ICD 10 PCS code

J. If other treatment, provide details

K. How did injury occur

L In case of accident

i. Is it RTA: ☐ 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 ☐ I ☐ A

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

DETAILS OF PATIENT ADMITTED

A.	Date of admission	03/01/2024 (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	03 Days
F.	Days in ICU	Days
G.	Room Type	
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	25000/-

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. [illegible]

b. Qualification:

c. Registration number with State code

Medway JSP Hospitals
No: 76, Kanchipuram High Road
Chengalpattu - 603 002

Hospital Seal
(Must include Hospital ID)

Pavithra k.

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: Gnana Prakash

b) Contact Number: 8667843135 email-Id (optional)

c) Patient's / Insured's Signature: Pavithra.k

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 / 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 JSP Hospitals
No: 70, Kanchipuram High Road
Chengalpattu - 603 002

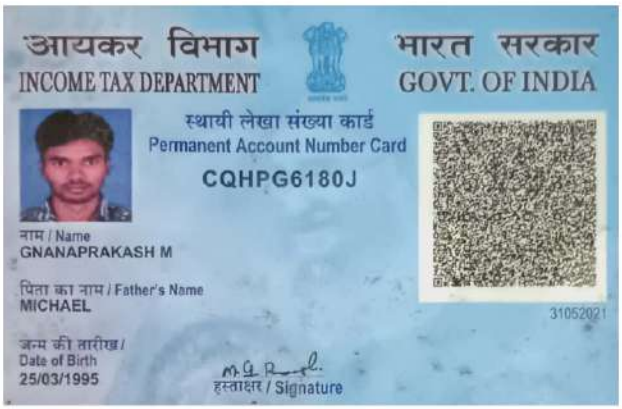
Date:

Doctor's Signature

The New India Assurance Company Limited

Card No.	:	CHE-NI-T1090-001-0001437-A
Name	:	GNANAPRAKASH MICHEAL MICHEAL
Gender	:	MALE
Age	:	28 Years
Employee Code	:	17191362
Company Name	:	TPI COMPOSITES INDIA PVT LTD
Valid From	:	04-Sep-2023

VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR



आयकर विभाग
INCOME TAX DEPARTMENT

भारत सरकार
GOVT. OF INDIA

स्थायी लेखा संख्या कार्ड
Permanent Account Number Card

CQHPG6180J

नाम / Name
GNANAPRAKASH M

पिता का नाम / Father's Name
MICHAEL

जन्म की तारीख / Date of Birth
25/03/1995

हस्ताक्षर / Signature

31052021

भारत सरकार
Government of India

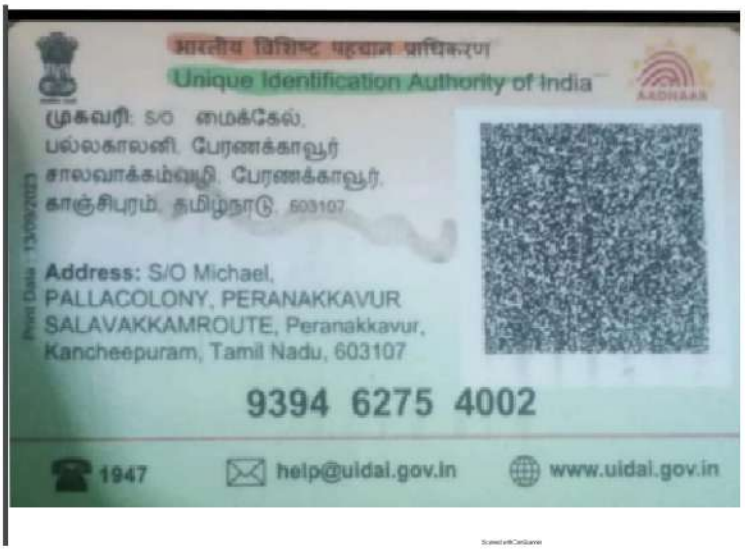
ஞானபிரகாஷ் மை
Gnanaprakash M
பிறந்த நாள் / DOB : 25/03/1995
ஆண் / Male

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

Issue Date : 24/02/2013

9394 6275 4002

मेरा आधार, मेरी पहचान



भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

முகவரி: S/O மைக்கேல்,
பல்லகாலனி, பேரணக்காவூர்
சாலவாக்கம்வழி, பேரணக்காவூர்,
காஞ்சிபுரம், தமிழ்நாடு, 603107

Address: S/O Michael,
PALLACOLONY, PERANAKKAVUR
SALAVAKKAMROUTE, Peranakkavur,
Kancheepuram, Tamil Nadu, 603107

Print Date : 13/09/2023

9394 6275 4002

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

Medway JSP Hospitals®
The way to better health

Mr.GNANAPRAKASH
28/Male/MHC202400493
03/01/2024/IPC2024000023
Dr ARTHI (ANESTH)

CASH SHEET

NAME: MR. GNANA PRAKASH. M AGE: 28 SEX: MALE

OCCUPATION: TPI COMPANY WORKER BED NO: 57/55

ADDRESS: No.1, PALLA COLONY, KANCHEPURAM

I.P. NO.: 0023/24

D.O.A.: 03:01:24 TIME: 22:43 PM

D.O.D.: TIME:

PHONE/MOBILE: 9597077082 REF. Dr.: Casualty

ADVANCE		DUES		CONSULTANTS
DATE	AMOUNT	DATE	AMOUNT	Dr. ARTHI (ANAES)
TOTAL				

INVESTIGATIONS

ANY SPECIAL PROCEDURES

1.
2.
3.

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

CLINICAL EXAMINATION NOTES

A 28 year old male came to hospital with

c/o - fever x 5 days

c/o - cold / cough x 5 days.

c/o - headache / chills / rigor

N/H/O - vomiting / abd pain / loose stools

N/H/O - burning micturition.

N/K/C/O - DM / HTN / BA / TB / epilepsy.

Nil surgical intervention in the past

T - 100°F
PR - 106bpm
BP - 110/80mmHg
SpO_2 - 98% in RA
RR - 24/min

O/E pt conscious
oriented
afebrile.

S/E CVS - S_1, S_2 (+)
RS - B/L AE (+)
P/A - soft
CNS - NFND

Δ = AFI.

Todb widal dilution positive (1:160)

RFT / LFT
S. electrolytes
urine routine

Rx

Ivf 1 (D) NS @ 50ml/hr.
Inj' rocef 1gm IV BD (ATS)
Inj' pcm 1gm IV SOS
Inj' pan 40mg IV BD
Inj' emeset 2cc IV SOS
T. Dolo 650 1-1-1
T. cetrizine 0-0-1

Medway JSP Hospitals

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(A Unit of United Alliance Healthcare Pvt Ltd)

(1)

GRAPHIC (T

Mr. GNANAPRAKASH
Male/MHC2024004933
IPC2024000023

Name Gnanaprakash Age 28/m

DATE	3/1/24	4/1/24						
No. of DAYS	(1)	(2)						
DAYS POST OP.								
TIME	6.00 2 6.00	6.00 2 6.00						
PULSE	°C TEMP °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 Temp	98						
120 160	36.1	97						
110 140	35.6	96						
100 120	35.0	95						
90 100	RESP 60							
80 80	50 Pulse							
70 60	40							
60 40	30							
50 20	20							
40 B.R.O	10 Resp							
STOOLS								
URINE	voided	voided						
	—							
SPUTUM	—	—						
WEIGHT	—							
BATH	given	given						

Medway JSP Hospitals

Mr.GNANAPRAKASH
28/Male/MHC202400493
03/01/2024/IPC2024000023
Dr.ARTHI (ANESTH)

Ipattu - 2.

NAME : GnanaPrakash

I.P. No. : 0023/24 Age : 28 Sex : M

RT

D.O.A. : 3/1/24

D.O.D. :

Consultants(s) : Dr Arthi (Ans)

S.No.	Drug Name	Strength Mg.	Frequency Route	1 M	1 A	1 N	14 M	14 A	24 N	Any Special Instruction
1.	INJ: XONE (ATD)	1gm	IV BD	R						
2	INJ: PAN	40mg	IV BD							
3	INJ: EMSET	2cc	IV BD							
4	INJ: PARA	1gm	IV ~~BD~~ SOS							
5	~~TAB: Dolo 650mg~~	1	P/O ~~TDS~~ SOS							
6.	~~TAB: Cetrazine~~	1	P/O ~~HS~~							

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Laboratory Test Result

Patient Name	:	**Mr.GNANAPRAKASH**	Patient Id	:	MHC202400493
Visit No	:	IPC2024000023	Sample ID	:	CMSer15174
Age	:	28	Order Date	:	04/01/2024
Gender	:	Male	Collection Date & Time	:	04/01/2024 12:10:39AM
Visit Type	:	IP	Receiving Date & Time	:	04/01/2024 12:10:53AM
Patient Ph No	:	9597077082	Report Date & Time	:	04/01/2024 12:13:36AM
Ward/Bed	:	LABOUR WARD / L1	Doctor Name	:	Dr.ARTHI (ANESTH)

Investigation	Value	Unit	Biological Reference Value
BIOCHEMISTRY			
CREATININE	1.1	mg/dL	0.9 - 1.3
(Method : *Jaffes)*			
(Specimen : *Serum)*			
ELECTROLYTES			
Sodium (Na+)	142	mmol/L	136 - 145
(Method : *ISE Indirect)*			
(Specimen : *Serum)*			
Potasium (K+)	3.8	mmol/L	3.5 - 5.1
(Method : *ISE Indirect)*			
(Specimen : *Serum)*			
Chlorides (Cl-)	102	mmol/L	96 - 106
(Method : *ISE Indirect)*			
(Specimen : *Serum)*			
Bicarbonate (HCo3)	23	mmol/L	22 - 29
(Method : *PEP Carboxylase)*			
(Specimen : *Serum)*			
UREA	31	mg/dL	12.8 - 49.2
(Method : *Urease)*			
(Specimen : *Serum)*			
GLUCOSE (RANDOM)	148	mg/dL	80 - 140

Dr.Monica Kumbhat.,

LAB DIRECTOR

PRAKASH

Result Entered By

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

Medway JSP Hospitals
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Laboratory Test Result

Patient Name	:	**Mr.GNANA PRAKASH**	Patient Id	:	MHC202400188
Visit No	:	DG202400047	Sample ID	:	CMWho14669
Age	:	28	Order Date	:	02/01/2024
Gender	:	Male	Collection Date & Time	:	02/01/2024 2:59:10PM
Visit Type	:	Diagnostics	Receiving Date & Time	:	02/01/2024 2:59:29PM
Patient Ph No	:	8667843135	Report Date & Time	:	02/01/2024 3:02:55PM
			Doctor Name	:	Dr.MEDWAY JSP

Investigation	Value	Unit	Biological Reference Value
HAEMATOLOGY			
CBC			
TWBC	5700	Cells/cu mm	4000 - 10000
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **NEUTROPHILS**	80	%	40 - 80
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **LYMPHOCYTES**	16	%	20 - 40
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **EOSINOPHILS**	04	%	01 - 06
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **MONOCYTES**	00	%	02 - 10
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **BASOPHILS**	00	%	0 - 2
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **HAEMOGLOBIN**	14.9	g/dL	13 - 17

Dr.Monica Kumbhat.,

LAB DIRECTOR

SUNDARI

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Patient Name : **Mr.GNANA PRAKASH**		Patient Id	: MHC202400188
Visit No	: DG202400047	Sample ID	: CMWho14669
Age	: 28	Order Date	: 02/01/2024
Gender	: Male	Collection Date & Time	: 02/01/2024 2:59:10PM
Visit Type	: Diagnostics	Receiving Date & Time	: 02/01/2024 2:59:29PM
Patient Ph No	: 8667843135	Report Date & Time	: 02/01/2024 3:02:55PM
		Doctor Name	: Dr.MEDWAY JSP

Investigation	Value	Unit	Biological Reference Value
(Method : *Colorimetric*) (Specimen : *Whole blood*) **HAEMATOCRIT**	45.5	%	40 - 50
(Method : *Calculated*) (Specimen : *Whole blood*) **TRBC**	5.2	Millions/cu mm	3.8 - 4.8
(Method : *Electrical Impedence*) (Specimen : *Whole blood*) **MCV**	86.0	fL	83 - 101
(Method : *Calculated*) (Specimen : *Whole blood*) **MCH**	28.2	pg	27 - 32
(Method : *Calculated*) (Specimen : *Whole blood*) **MCHC**	32.7	g/dL	31.5 - 34.5
(Method : *Calculated*) (Specimen : *Whole blood*) **PLATELET**	1.76	Cells/cu mm	150000 - 400000
(Method : *Electrical Impedence*) (Specimen : *Whole blood*) **SEROLOGY**			
C.R.P. (C-Reactive Protein)	Positive 48	mg/L	< 5.0
(Method : *Particle-enhanced immunoturbidimetric assay*) (Specimen : *Serum*)			

Dr.Monica Kumbhat.,

LAB DIRECTOR

SUNDARI

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Patient Name	:	**Mr.GNANA PRAKASH**	Patient Id	:	MHC202400188
Visit No	:	DG202400047	Sample ID	:	CMSer14668
Age	:	28	Order Date	:	02/01/2024
Gender	:	Male	Collection Date & Time	:	02/01/2024 2:59:10PM
Visit Type	:	Diagnostics	Receiving Date & Time	:	02/01/2024 2:59:29PM
Patient Ph No	:	8667843135	Report Date & Time	:	02/01/2024 3:02:55PM
			Doctor Name	:	Dr.MEDWAY JSP

Investigation	Value	Unit	Biological Reference Value
WIDAL SLIDE			
S. Typhi ' O '	Positive 1 : 160 Dilution		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Typhi ' H '	Positive 1 : 160 Dilution		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Para Typhi 'A (H)'	Negative 1 : 20 Dilution		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Para Typhi 'B (H)'	Negative 1 : 20 Dilution		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			

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

Dr.Monica Kumbhat.,

LAB DIRECTOR

SUNDARI

Result Entered By

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