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

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: MEDWAY JSP HOSPITALS

Hospital location: CHENGAL PATTU

Hospital ID:

Hospital email ID: [illegible]@medwayhospitals.com

PRISHNI 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. RAJALAKSHMI

b) Gender: ☐ Male ☑ Female ☐ Third gender c) Contact no.: 9789523915 d) Alternate contact no.:

e) Age: Years 71 Months f) Date of birth: g) Insurer ID card no.: 505564361616

h) Policy number/Name of corporate: RANE TRW STEERING SYSTEM PVT Ltd i) Employee ID: 14855

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: Salaried

m) Address of insured patient: Enclosed

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor: DR. ARVIND KUMAR b) Contact no.: 07[illegible]829

c) Name of Illness/disease with presenting complaints: Pain in (L) shoulder & Giddiness

d) Relevant clinical findings:

e) Duration of the present ailment: days e.1) Date of first consultation:

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

f) Provisional diagnosis: Peripheral vertigo | ? Fracture (R) neck of femur

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:

h.1) Route of drug administration: ☑ IV ☑ Oral ☐ Other IV | Oral

i) If Surgical, name of surgery:

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:

DETAILS OF THE PATIENT ADMITED

a) Date of admission: 17/01/2024 b) Time of admission: c) This is ☑ an emergency/ ☐ a planned hospitalization event

d) Expected no. of days stay in hospital: 4 Days e) Days in ICU: Days f) Room type: Single room

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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. 40000/-

p. Mandatory past history of any chronic illness. If yes (since month/year)

- [x] 1. Diabetes
- [x] 2. Heart Disease
- [x] 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. ARAVIND 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: MRS. CHANDRIKA

b) Contact number: 9718952915 c) Email ID: (Optional)

d) Patient's / Insured's signature: Date: 17/01/2020 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: 119916

Date: Time:

United India Insurance Company Ltd.

Beneficiary:	Rajalakshmi M
Medi Assist ID:	5055643616
Relation:	Mother
Primary insured:	Varadharajan M
Policy holder:	Rane TRW Steering Systems Private Limited
Policy No:	5002002823P104017676
Policy Period:	01 Jul 2023 To 30 Jun 2024
Generated On:	18 Dec 2023 16:43

Mrs.RAJALAKSHMI M
77/Female/MHC2024026 14
17/01/2024/IPC2024000143
Dr.ARTHI

Medway JSP Hospitals®
The way to better health

CASH SHEET

NAME Mrs. Rajalakshmi AGE 77 SEX F

OCCUPATION : BED NO. W

ADDRESS : No. 347/165, I.P. NO. : 143/24

Annasalai, D.O.A. : 17/01/24 TIME 01:50 pm

Chengalpattu (DT) D.O.D. : TIME

PHONE/MOBILE : 9789523015 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 77 year old female came to hospital with c/o - pain in (L) shoulder.

C/O - Giddiness and fall around 12:00PM.

N/H/O - headache / vomiting / nausea

N/H/O - weakness of limbs / deviation of angle of mouth

N/H/O - chest pain / breathlessness

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

Airway
breathing | Adequate
circulation

T - (N)
BP - 80/60mmHg
PR - 72 bpm
CBG - 96 mg/dl.
GCS - 15/15.

O/E pt conscious
oriented
Afebrile

S/E CVS - S_1S_2 (+)
RS - B/L AE (+)
P/A - soft
CNS - moves all 4 limbs

Δ = ? vertigo

Rx
IVF 1 ORL @ 50ml/hr.
1 DNS @ 50ml/hr

Inj pan 40 IV BD
Inj emeset 2cc IV SOS
T. vertin 1 - 0 -
T. ~~BBA~~ Hifenac-P 1-0-

vitals monitoring.

To do
- CT-brain
- CBC
- RFT
- LFT
- S. electrolytes
- Urine routine

To add (TC - 12,800)
Inj xone 1gm IV BD (ATD).

HHC0024076/4

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Phone : 2742 6829, 2742 8851

(1)

ADDITIONAL CASE SHEET

NAME : Mrs. Rajalakshmi BED No. : ICU-11 IP. No. : 01H6/24

DATE & TIME	CLINICAL NOTES	INVESTIGATION	TREATMENT
2/1/2024			

17/1/24

S/B Dr. [illegible]

D: [illegible] for [illegible]

pt: conscious

[illegible]

PR: 80/min

CVS/RS

BP: 90/60

CBC

[illegible]

RBS

RFT

CT

[illegible] (CT)

H:

1. [illegible] - [illegible]

2. [illegible]

[signature]

MHC00040614.

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ADDITIONAL CASE SHEET

NAME : MRs. Rajalakshmi BED No. : ICU-II IP. No. : 043

DATE & TIME	CLINICAL NOTES	INVESTIGATION	TREATMENT
17/01/24 3PM.	S/B DR. Arvind Kumar		
	c/o pain in (L) shoulder, (R) Hip - older		
	H/o Trivial trauma (R)		
CBG- 94. BP- 100/60mmHg.	H/o giddiness and fall 1/2 hr ba		
	No H/o DM / HTN / Hypo.		
	O/E GCS 15/15 ac pain After		
	Tender (R) over Ant. Hip Joint line (R) Hip.		
	Tender (L) over (L) Acr AC Joint		
	Active SLRT Not possible (R) lower limb		
	Xray (L) shoulder, (L) Pelvis } NBC		

Adv

Xray Pelvis ē Both Hips in ml rotation — AP

? Fracture Neck of (R) Femur

T. Diclofenac- 75mg Inj

AF 1 amp

T. PAN 40m

BF

8200

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Mrs.RAJALAKSHMI M
77/Female/MHC2024026114
17/01/2024/IP2024000143
Dr.ARTHI

ADDITIONAL CASE SHEET

NAME : MRS: RAJALAKSHMI.M BED No. : II IP. No. : 0143

DATE & TIME	CLINICAL NOTES	INVESTIGATION	TREATMENT
17/1/24	S/B Dr. G. Arthi (Consultant) A case of Vertigo / ? # NOF - R O/E: Pt. Conscious Oriented BP: 90/60 PR: 82/min SpO_2: 100% (RA) RR: 23/min Afebrile CVS: S1S2 + RS: B/L AE + PA: Soft. BS + CNS: NFND G. Arthi		Plan X ray Pelvis & Both Hips Ortho Review Echo

17/01/2024
@ 9:30pm

S/B Duty Doctor

Dx: Vertigo ? Nor H

O/E:

Conscious
Oriented.
Afebrile

Vital
T - (N)
P - 100/Bpm
BP - 130/80mm Hg
SpO2 - 98% RA

O/E
CVS S1S2 (+)
RS - B/L AE (+)
P/A Soft
CNS - NFND

Rx

- To Continue the Same
- To Observe Carefully (c)

[signature]
2140 hrs

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Mrs.RAJALAKSHMI M
77/Female/MHC2024026114
17/01/2024/IPC2024000143
Dr.ARTHI

ADDITIONAL CASE SHEET

NAME : MRS: RAJALAKSHMI M BED No. : II IP. No. : 0143

DATE & TIME	CLINICAL NOTES	INVESTIGATION	TREATMENT
18/01/24 8:30 am	S/B Dr. Ismail Allo Peripheral vertigo / ? (R) NOF # PA received c/o pain over (R) shoulder joint PR- 86/min BP- 110/70 mmHg SPO2- 97% RA Temp- (N) O/E: Conscious, oriented, afebrile CVS- S_1S_2 (N) RS- BILAE (N) CNS- NFND PIA- Soft		Adv: - Oral Hydration @ 2l/day - IVF NS @ 50ml/hr. (D) Inj. Xone 1gm IV BD - Inj. Pan 40mg IV BD - Inj. Emeset 4mg IV BD (Stop) - Tab. Vertin 16mg 1-0-1 - Tab. Hifenac TH 8mg 1-0-1 - Tab. Gladvert 25mg 1-0-1 - Tab. Valparin CR 300mg 1-0-1
To get: Cardiologist opinion			

AS Ismail

MRS. RAJALAKSHMI M
77/Female/MHC202402614
17/01/2024/IPC2024000143
Dr.ARTHI

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T.P.R.) CHART

Name: Mrs. RAJALAKSHMI . M   Age: 77   MRD No. MHC 202402614

DATE			17/1/24	18/1/24				
No. of DAYS			(1)	(2)				
DAYS POST OP.								
TIME			8 6 10 8 6 10	8 6 10 8 6 10				
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	36.7	98						
120 / 160	36.1	97 Temp						
110 / 140	35.6	96						
100 / 120	35.0	95						
90 / 100	RESP 60							
80 / 80	50 PR							
70 / 60	40							
60 / 40	30							
50 / 20	20							
40 / B.R.O	10 RR							
STOOLS			✓	✓				
URINE			voided	voided				
BP			90/60	100/60				
SPUTUM			–	–				
WEIGHT			–	–				
BATH			✓	✓				

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77/Female/MHC202402614
17/01/2024/IPC2024000143
Dr.ARTHI

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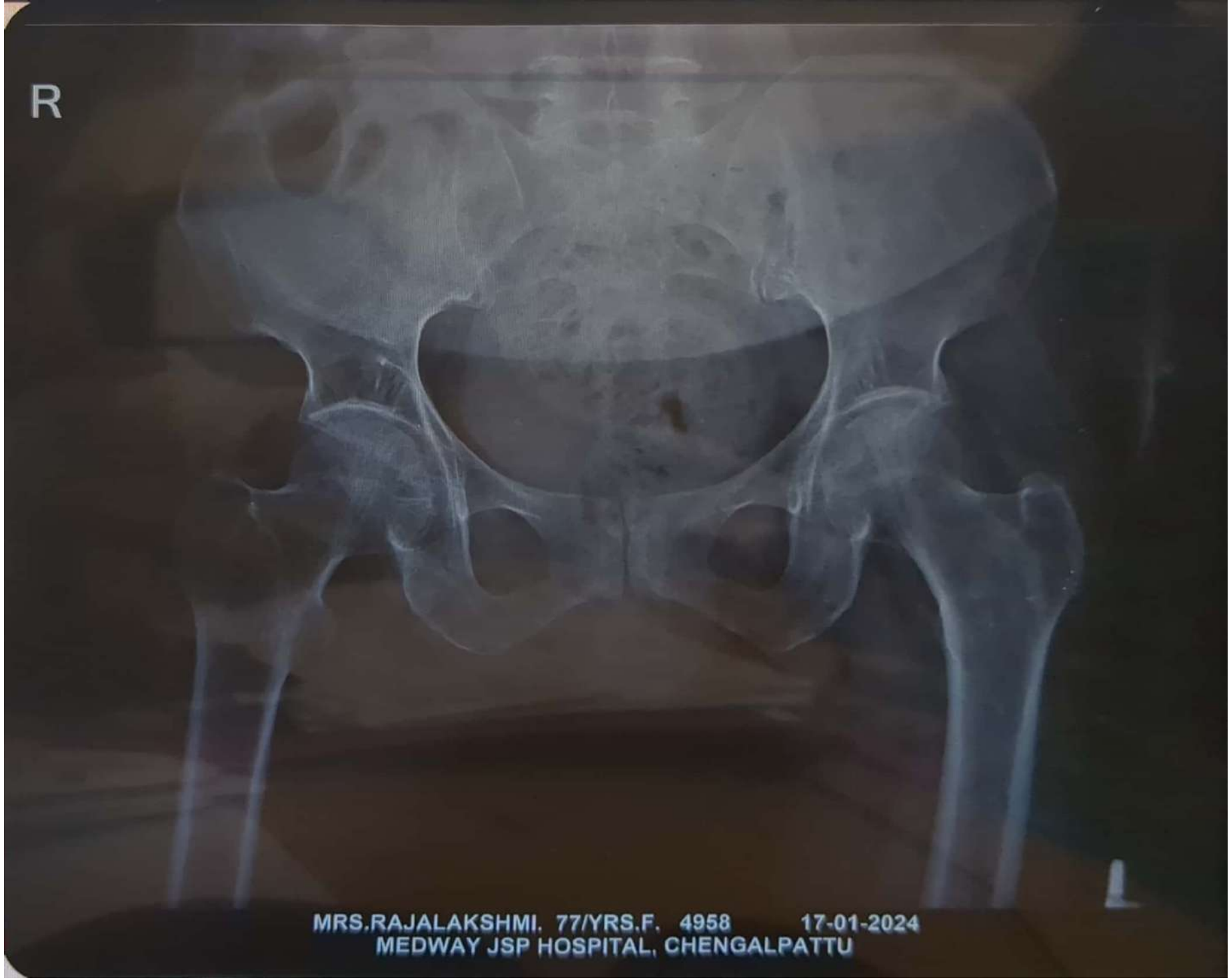
D.O.A. : 17/01/2024
D.O.D. :
Consultants(s) : Dr. ARTHI

NAME : Mrs. RAJALAKSHMI
I.P. No. : 0143 Age : 77 Sex : Female

TREATMENT CHART

S.No.	Drug Name	Strength Mg.	Frequency Route	17 M	17 A	17 N	18 M	18 A	18 N	Any Special Instruction
1.	INJ: ROCEPHIN (ATD)	1GM	IV BD		D1	8PM	8AM	D2		
2.	INJ: PAN	40MG	IV BD			8PM	8AM			
3.	INJ: EMESET	2cc	IV BD			8PM	8AM			
4.	TAB: VERTIN	16MG	P/O 1-0-1			8PM				
5.	TAB: HIFENAC TH	8	P/O 1-0-1			8PM				
6.	TAB: VALPARIN CR	300MG	P/O 1-0-1			8PM				
7.	TAB: GLADVERT	25MG	P/O 1-0-1			8PM				

→ STOP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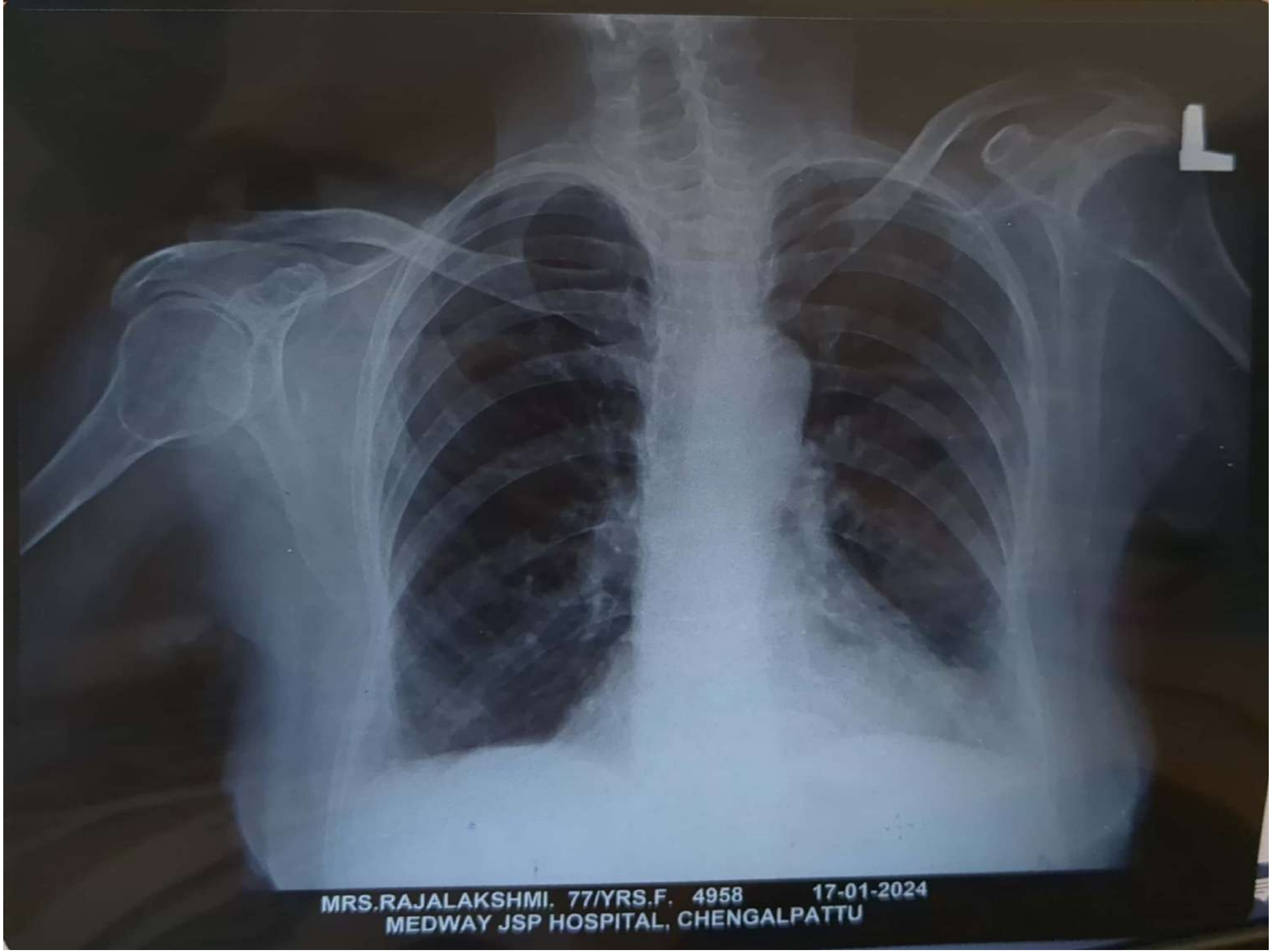
MRS.RAJALAKSHMI. 77/YRS.F. 4958 17-01-2024
MEDWAY JSP HOSPITAL, CHENGALPATTU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