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

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 Isp Hospitals
	i. Address	Chengalpattu
	ii Rohini id	
	iii. e-mail id	cglinsurance@medwayhospitals.com

TO BE FILLED BY INSURED/PATIENT

A.	Name of the Patient :	Mrs. Thirupuram. T
B.	Gender:	☐ Male ☑ Female ☐ Third Gender
C.	Age:	53 (Years) / (Month)
D.	Date of Birth:	(DD/MM/YYYY)
E.	Contact number:	98403-05609
F.	Contact number of attending Relative:	
G.	Insured Card ID number	DEL-01-H0351-003-0006969-D
H.	~~Policy number~~ / Name of Corporate.	Statestreet HCC Services India pvt ltd
I.	Employee ID:	51840947
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:	Enclosed
O.	Occupation of Insured patient	Salaried

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor: Dr S UDHA

B. Contact number: 27426825

C. Nature of Illness / Disease with presenting complaint: Fever for 5 days

D. Relevant Critical Findings:

E. Duration of the present ailment: 5 Days

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

ii. Past history of present ailment, if any

F. Provisional diagnosis: AFI / UTI

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 Enclosed

i. Route of Drug Administration : IV / IM / oral

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 ☐ L ☐ A

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

DETAILS OF PATIENT ADMITTED

A.	Date of admission	21/1/2024 (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	/ Hypothyroidism
E.	Expected number of Days / stay in hospital	3 Days
F.	Days in ICU	___ Days
G.	Room Type	Single room
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	40,000/-

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. Sudha
b.	Qualification:	
c.	Registration number with State code	

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: Mr. Thulasangam

b) Contact Number: 98403-05009 email-Id (optional)

c) Patient's / Insured's Signature: S Thulpan

Date: 22/1/24 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

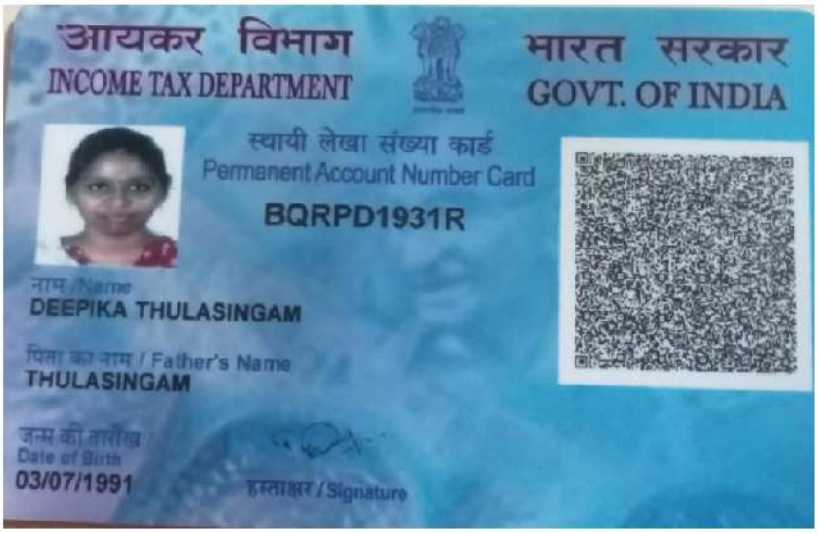
Doctor's Signature

Date: Time:

THE ORIENTAL INSURANCE CO. LTD.

VIDAL HEALTH

Card No : DEL-OI-H0351-003-0006969-D
Card Holder : THIRUPURAM T
Sex : F Age : 50 Year/s
STATESTREET HCL SERVICES INDIA PRIVATE LIMITED
Valid From. : 01-Oct-2020
Emp SAP ID 51840947



आयकर विभाग
INCOME TAX DEPARTMENT

भारत सरकार
GOVT. OF INDIA

स्थायी लेखा संख्या कार्ड
Permanent Account Number Card

BQRPD1931R

नाम / Name
DEEPIKA THULASINGAM

पिता का नाम / Father's Name
THULASINGAM

जन्म की तारीख
Date of Birth
03/07/1991

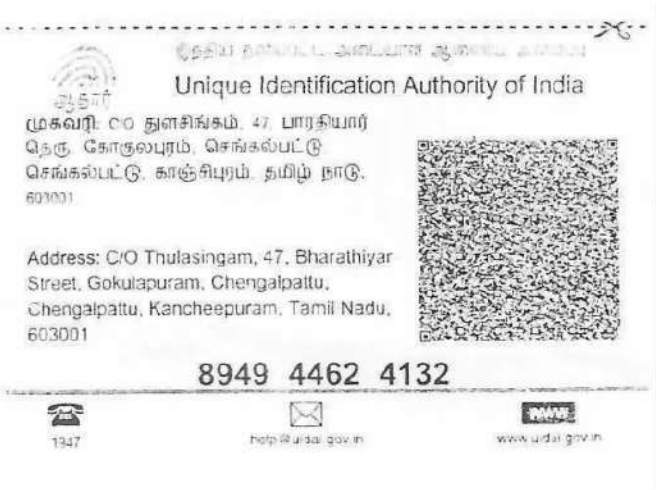
हस्ताक्षर / Signature

இந்திய அரசாங்கம்
Government of India

திருபுரம் துளசிங்கம்
Thirupuram Thulasingam
பிறந்த நாள் / DOB : 17/04/1979
பெண்பால் / Female

8949 4462 4132

எனது ஆதார், எனது அடையாளம்



Unique Identification Authority of India

முகவரி: C/O துளசிங்கம், 47, பாரதியார் தெரு, கோகுலபுரம், செங்கல்பட்டு செங்கல்பட்டு, காஞ்சிபுரம், தமிழ் நாடு, 603001

Address: C/O Thulasingam, 47, Bharathiyar Street, Gokulapuram, Chengalpattu, Chengalpattu, Kancheepuram, Tamil Nadu, 603001

8949 4462 4132

1947

help@uidai.gov.in

www.uidai.gov.in

Mrs.THIRUPURAM
53/Female/MHC202403300
21/01/2024/IPC2024000189
Dr.ARTHI

Medway JSP Hospitals®
The way to better health

CASH SHEET

NAME MRS. THIRUPURAM AGE 53 SEX F

OCCUPATION : HOME MAKER BED NO. ICU

ADDRESS : NO. 47, BHARATHIYAR I.P. NO. : 0189/24

ST, GOKULA PURAM, D.O.A. : 21/1/24 TIME 7.54PM

Chengal pattu. D.O.D. : TIME

PHONE/MOBILE : 9840305604 REF. Dr. CASUALTY

ADVANCE

DATE	AMOUNT
TOTAL	

DUES

DATE	AMOUNT

CONSULTANTS

Dr. Arthi (Anes)

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 53 year female was brought by her attenders with Complains of fever on + off x 5 days
c/o dysuria (burning micturition) x 4 days
Chills x 1 days

C/o generalised weakness, (↓) appetite.
N/o c/o Cough / cold / Abd pain / loose stool
K/c/o DM ↓ rxn – (T. Glyconorm GP-1)
Hypothyroidism – (T. Thyronorm 25mg)
S/H/o Sx done. No major surgical history

Δ: AFI / ? UTI / T2DM

O/E:
Conscious
Oriented
Febrile
Hydration – poor

T – 101°F
PR – 112/min
BP – 130/80 mmHg
SpO2 – 93% RA

S/E:
CVS – S1 S2 ⊕
RS – BAE ⊕
PA – Soft, BS ⊕
CNS – NFND

TC – 9600
Poly – 65%
Plt – 2.34
} WNL

Urine:
Pus – Plenty
Pr – ⊕
Glucose ⊕

CRP – 48

Widal – weakly (+ve)

To do:
Urine C/S
get Thy opd – Dr Sudha MD

Rx:
Adq hydration
DM diet

IVF – 1 NS @ 100
Inj Xone 1g IV BD
Inj Pan 40mg IV BD
Inj Emeset 4mg IV B
T. Nitrobact 100mg – –
T. Azee 500mg – –
T. Paracetamol – –
Inj. Para 1g IV (SOS)

Vitals monitoring

[signature]
12.30 hr

(1)

Medway JSP Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

No.70, Kanchipuram High Road, Chengalpattu - 2.

Phone : 2742 6829, 2742 8851

ADDITIONAL CASE SHEET

NAME : Mrs Thirupuram BED No. : [illegible] IP. No. : 0184

DATE & TIME	CLINICAL NOTES	INVESTIGATION	TREATMENT
22/01/24 10 Am	S/B Dr. Mahendran		
	UTI / T2DM / SHT	Hypothyroid	c/o Loose stools
	O/E pt Conscious oriented afebrile Hydration fair	R	Oral Hydration 2-3L/day
T - (N)			IVF NS 20 50ml/hr
Bp - 120/80mmHg	CVS - S1S2 (+)		(D1) Inj. Xone 1gm IV BD
PR - 94/min	RS - BAE (+)		Inj. pan 40mg IV BD
SpO2 - 98% in RA	P/A soft		Inj. Emeset 4mg IV BD
	CNS - NFND		T. nitrobact 100mg 1-0-1
			C. Bifilac 1-0-1
			T. pb 10mg 1-1-1
TO do			T. urispas 200mg 1-0-1
- urine c/s		old drugs	T. Telmikind 40mg 1-0-0
- USG - abd & pelvis			T. Glycomet GP1 1-0-0
			Bp / GTR / F/o chart
			T. Thyronorm 25mcg 1-0-0

Medway JSP Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

GRAPHIC

Mrs. THIRUPURAM
53/Female/MHC2024033100
21/01/2024/IPC2024000189
Dr ARTHI

Name Mrs. Thirupuram Age 53/F

DATE			21/1/24	22/1/24						
No. of DAYS			1	2						
DAYS POST OP.										
TIME			2 6 10	2 6 10						
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	PR						
60	40		30							
50	20		20							
40	BRO		10	RR						
STOOLS				✓	✓					
URINE				Vo Pdeu	Vo Pdeu					
BP				130/80						
SPUTUM				–	–					
WEIGHT				–	–					
BATH				✓	✓					

Medway JSP Hospitals
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)
No.70, Kanchipuram High Road, Chengalpattu - 2.
Phone : 2742 6829, 2742 8851

NAME : Mrs.THIRUPURAM
53/Female/MHC202403300
21/01/2024/IPC2024000189
Dr.ARTHI

I.P. No. :

Sex : F

D.O.A. : 21/1/24

D.O.D. :

Consultants(s) : Dr Arthi (Any)

TREATMENT CHART

S.No.	Drug Name	Strength Mg.	Frequency Route	21/1 M	21/1 A	21/1 N	22/1 M	22/1 A	22/1 N	Any Special Instruction
1.	INJ: XONE(ATD)	1G	IV BD		D1	8PM	6AM	D8	6PM	
2.	INJ: RAZO	20MG	IV BD			10PM	6AM		6PM	
3.	INJ: ENESET	8CC	IV BD			10PM	6AM		6PM	
4.	INJ: PARA	1G	IV SOS			9PM				
5.	TAB: AZEE	500MG	P/O 0-1-0		D1	8PM		D8		2
6.	TAB: DOLO	650MG	P/O 1-1-1-1			10PM	9AM		2PM	
7.	TAB: NITROBACT	100MG	P/O 1-0-1			10PM	9AM			
8.	TAB: BIFILAC		P/O 1-0-1				9AM			
9.	TAB: ORISPAZ	200MG	P/O 1-0-1				9AM			
10	TAB: TELMIKIND	40MG	P/O 1-0-0				9AM			
11	TAB: GLYCOMET	4PI	P/O 1-0-0				9AM			

Laboratory Test Result

Patient Name	: **Mrs.THIRUPURAM**	Patient Id	: MHC202403300
Visit No	: IPC2024000189	Sample ID	: CMPla21132
Age	: 53	Order Date	: 22/01/2024
Gender	: Female	Collection Date & Time	: 22/01/2024 7:24:24AM
Visit Type	: IP	Receiving Date & Time	: 22/01/2024 7:26:05AM
Patient Ph No	:	Report Date & Time	:
Ward/Bed	: GENERAL WARD(GYNEC) / 12	Doctor Name	: Dr.ARTHI

Investigation	Value	Unit	Biological Reference Value
BIOCHEMISTRY			
GLUCOSE (FASTING)	182	mg/dL	70 - 110

(Method : *Hexokinase*)
(Specimen : *Plasma*)

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

INTERIM REPORT

Dr..,

ROSHINI
Result Entered By

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

Laboratory Test Result

Patient Name	:	**Mrs.THIRUPURAM**	Patient Id	:	MHC202403222
Visit No	:	DG202400967	Sample ID	:	CMWho20937
Age	:	53	Order Date	:	21/01/2024
Gender	:	Female	Collection Date & Time	:	21/01/2024 11:34:34AM
Visit Type	:	Diagnostics	Receiving Date & Time	:	21/01/2024 11:34:52AM
Patient Ph No	:		Report Date & Time	:	21/01/2024 12:01:02PM
			Doctor Name	:	Dr.MEDWAY JSP CASUALTY

Investigation	Value	Unit	Biological Reference Value
HAEMATOLOGY			
CBC			
TWBC	9600	Cells/cu mm	4000 - 10000
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **NEUTROPHILS**	65	%	40 - 80
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **LYMPHOCYTES**	30	%	20 - 40
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **EOSINOPHILS**	05	%	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***	12.8	g/dL	12.0 - 15.0

Dr.Monica Kumbhat.,

LAB DIRECTOR

SUNDARI

Result Entered By

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

Patient Name	:	**Mrs.THIRUPURAM**	Patient Id	:	MHC202403222
Visit No	:	DG202400967	Sample ID	:	CMWho20937
Age	:	53	Order Date	:	21/01/2024
Gender	:	Female	Collection Date & Time	:	21/01/2024 11:34:34AM
Visit Type	:	Diagnostics	Receiving Date & Time	:	21/01/2024 11:34:52AM
Patient Ph No	:		Report Date & Time	:	21/01/2024 12:01:02PM
			Doctor Name	:	Dr.MEDWAY JSP CASUALTY

Investigation	Value	Unit	Biological Reference Value
(Method : *Colorimetric*) (Specimen : *Whole blood*) **HAEMATOCRIT**	41.6	%	36 - 46
(Method : *Calculated*) (Specimen : *Whole blood*) **TRBC**	4.7	Millions/cu mm	3.8 - 4.8
(Method : *Electrical Impedence*) (Specimen : *Whole blood*) **MCV**	88.2	fL	83 - 101
(Method : *Calculated*) (Specimen : *Whole blood*) **MCH**	27.2	pg	27 - 32
(Method : *Calculated*) (Specimen : *Whole blood*) **MCHC**	30.6	g/dL	31.5 - 34.5
(Method : *Calculated*) (Specimen : *Whole blood*) **PLATELET**	2.34	Cells/cu mm	150000 - 400000
(Method : *Electrical Impedence*) (Specimen : *Whole blood*) **CLINICAL PATHOLOGY**			
URINE ROUTINE ANALYSIS			
COLOR	PALE YELLOW		STRAW YELLOW

Dr.Monica Kumbhat.,

LAB DIRECTOR

SUNDARI

Result Entered By

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

Patient Name	:	**Mrs.THIRUPURAM**	Patient Id	:	MHC202403222
Visit No	:	DG202400967	Sample ID	:	CMUri20935
Age	:	53	Order Date	:	21/01/2024
Gender	:	Female	Collection Date & Time	:	21/01/2024 11:34:34AM
Visit Type	:	Diagnostics	Receiving Date & Time	:	21/01/2024 11:34:52AM
Patient Ph No	:		Report Date & Time	:	21/01/2024 12:01:02PM
			Doctor Name	:	Dr.MEDWAY JSP CASUALTY

Investigation	Value	Unit	Biological Reference Value
(Method : *Macroscopy*) (Specimen : *Urine*) **APPEARANCE**	TURBID		CLEAR
(Method : *Macroscopy*) (Specimen : *Urine*) **PROTEIN**	(+)		NEGATIVE
(Method : *Automated (Protein Error Reaction)*) (Specimen : *Urine*) **GLUCOSE**	(*)		NEGATIVE
(Method : *Automated (Glucose Oxidase Reaction)*) (Specimen : *Urine*) **PUS CELLS**	PLENTY	/HPF	< 3
(Method : *Microscopy*) (Specimen : *Urine*) **Epi. Cells**	3-4	/HPF	< 5
(Method : *Microscopy*) (Specimen : *Urine*) **RBCs**	2-3	/HPF	
(Method : *Microscopy*) (Specimen : *Urine*) **Casts**	NIL	/HPF	
(Method : *Microscopy*) (Specimen : *Urine*)			

Dr.Monica Kumbhat.,
LAB DIRECTOR

SUNDARI
Result Entered By

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

Patient Name	: **Mrs.THIRUPURAM**	Patient Id	: MHC202403222
Visit No	: DG202400967	Sample ID	: CMUri20935
Age	: 53	Order Date	: 21/01/2024
Gender	: Female	Collection Date & Time	: 21/01/2024 11:34:34AM
Visit Type	: Diagnostics	Receiving Date & Time	: 21/01/2024 11:34:52AM
Patient Ph No	:	Report Date & Time	: 21/01/2024 12:01:02PM
		Doctor Name	: Dr.MEDWAY JSP CASUALTY

Investigation	Value	Unit	Biological Reference Value
Crystals	NIL	/HPF	
(Method : *Microscopy*) (Specimen : *Urine*)			
Others	-	/HPF	
(Method : *Microscopy*) (Specimen : *Urine*)			
SEROLOGY			
C.R.P. (C-Reactive Protein)	POSITIVE 48	mg/L	< 5.0
(Method : *Particle-enhanced immunoturbidimetric assay*) (Specimen : *Serum*)			
DENGUE - NS1 (FIA)	0.08		COI : <1.0 NEGATIVE >1.0 POSITIVE
(Method :) (Specimen : *Serum*)			
WIDAL SLIDE			
S. Typhi ' O '	POSITIVE 1 : 80 DILUTION		
(Method : *Slide Agglutination*) (Specimen : *Serum*)			
S. Typhi ' H '	POSITIVE 1 : 80 DILUTION		
(Method : *Slide Agglutination*) (Specimen : *Serum*)			
S. Para Typhi 'A (H)'	NEGATIVE 1 : 20 DILUTION		
(Method : *Slide Agglutination*) (Specimen : *Serum*)			

Dr.Monica Kumbhat.,
LAB DIRECTOR

SUNDARI
Result Entered By

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

Patient Name	:	**Mrs.THIRUPURAM**	Patient Id	:	MHC202403222
Visit No	:	DG202400967	Sample ID	:	CMSer20936
Age	:	53	Order Date	:	21/01/2024
Gender	:	Female	Collection Date & Time	:	21/01/2024 11:34:34AM
Visit Type	:	Diagnostics	Receiving Date & Time	:	21/01/2024 11:34:52AM
Patient Ph No	:		Report Date & Time	:	21/01/2024 12:01:02PM
			Doctor Name	:	Dr.MEDWAY JSP CASUALTY

Investigation	Value	Unit	Biological Reference Value
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