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

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: Medway JSF Hospitals

Hospital location: No 70, Kanchipuram High Road Hospital ID:

Hospital email ID: Chengalpattu - 603 002 ROHINI 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: ARUN KUMAR

b) Gender: ☑ Male ☐ Female ☐ Third gender c) Contact no.: 9791040293 d) Alternate contact no.:

e) Age: Years 32 Months f) Date of birth: g) Insurer ID card no.: 403997891/6

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: 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.: 9176[illegible]

c) Name of illness/disease with presenting complaints: c/o fever x 1 day, H/o sore throat (T), Generalized body pain (T)

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: Acute Febrile Illness / ?URTI / Pharyngitis

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 Drug chart Enclosed

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: 23/11/2019 b) Time of admission: c) This is ☐ an emergency/ ☐ a planned hospitalization event

d) Expected no. of days stay in hospital: 03 Days e) Days in ICU: Days f) Room type: Single

Medi Assist

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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. 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:

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: SRINIVASAN

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: Medway JSP Hospitals No: 70, Kancheepuram High Road Chengalpattu 603002

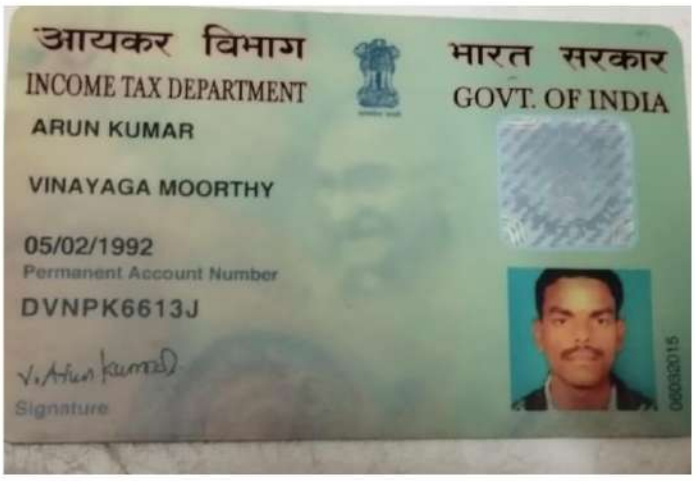
Doctor's signature:

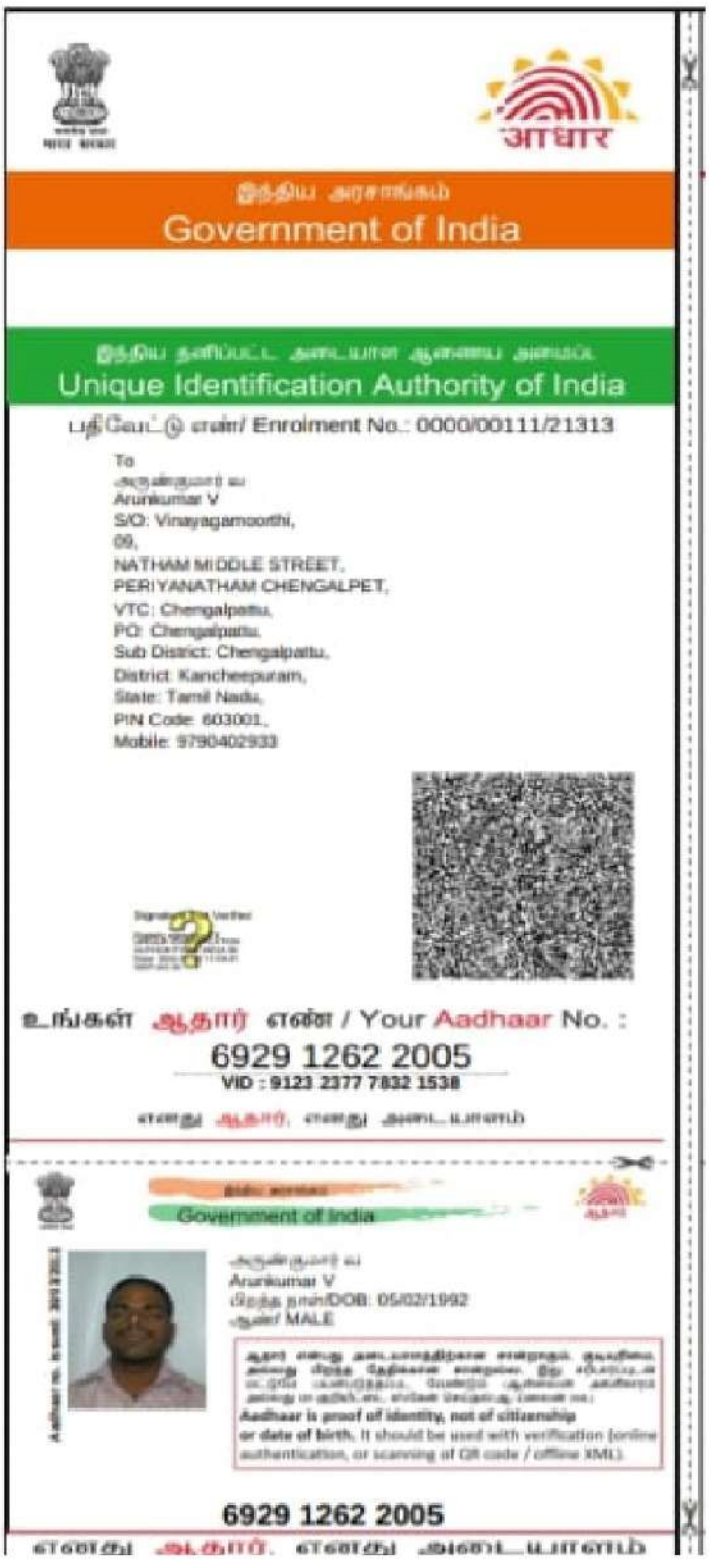
Date: Time:

Arunkumar V

Beneficiary name	Arunkumar V
Member ID	4039978916
Employee code	200919
Relation	Self
Date of Birth	02-May-1992
Primary insured	Arunkumar V
Valid upto	31-Mar-2024
Po	
Insurer ID	MEMBER1373

Download Complete at LOCATION: /storage/emulate...





Mr.ARUN KUMAR.V
32/Male/MHC202403574
23/01/2024/IPC2024000216
Dr.ARTHI

Medway JSP Hospital
The way to better health

CASH SHEET

NAME MR. ArunKumar AGE 32 SEX M

OCCUPATION : Super Gas. BED NO. G1

ADDRESS : No:9, Middle St, Big Natham, Chengalpattu I.P. NO. : 0216

D.O.A. : 03/1/24 TIME 12:57 Pm

D.O.D. : TIME

PHONE/MOBILE : 9790402933. REF. Dr. DR. Raja. DMO.

ADVANCE		DUES	
DATE	AMOUNT	DATE	AMOUNT
TOTAL			

CONSULTANTS

DR. Arthi (Anaes)

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

C/o fever - 1 day since yesterday morning associated with chills & rigor

H/o sorethroat ⊕, Generalized Body pain ⊕

NO H/o cough, abd. pain, vomiting, loose stools

NO H/o Burning micturition.

NO H/o difficulty in breathing, swelling of legs

H/o (Rt) patellar # - operated 2yrs before

H/o Rx for cholelithiasis - (Details NA) - Surgery done

N/K/C/O DM/HT/TB/BA

O/E pt Conscious
oriented
afebrile
Hydration fair
not Icterus
no pallor
CVS - S_1S_2 ⊕
RS - BAE ⊕
no added sounds
P/A soft
CNS - NFND

T - (N)
Bp - 110/60 mmHg
PR - 104/min
SpO_2 - 98% i/A

Cl E: Throat - post. pharyngeal wall inflamed

A: AFI (Days 2 of illness)
Pharyngitis

Rx
oral Hydration 2L/day
IVF - RL 10 100ml/hr
Inj. Zone 1g IV BD
Inj. Pan 40mg IV BD
Inj. Emeset 4mg IV BD
T. Azithral 250mg 1-0-0
T. Para 650mg 1-1-1
vitals monitoring

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

Mr.ARUN KUMAR.V
32/Male/MHC20240 3574
23/01/2024/IPC2024000216
Dr ARTHI

ADDITIONAL CASE SHEET

NAME : Mr. Arun kumar BED No. : 61 IP. No. : 0216/24

DATE & TIME	CLINICAL NOTES	INVESTIGATION	TREATMENT
23/1/2023		PB Osthari	
		H/o Fever 3 day	
		H/o Sore throat (+)	
		H/o Runny nose (+)	
		H/o Headache (+)	
		HT / DM L X X	BA X — Ocal 1 HT 2-3 Co
		Pt conscious oriented	— Inj Clavam 1.2g IV BD ATD.
	BP 110/70	CVS S1S2	Tab Stop x2
	PR 80/m	RS NVBS	— T. Azithral 500 1-0-1
	TC 11850	P/A Soft	— T Cetzine 0-0-1
	LFT c hui Enz Pomi	CNS Conscious Oriented	— T Dolo 650 1-1-1
			— Inj Pan 40 IV BD
			— Rx Ensel 4g 1 IV
		Diag AFI (Day 2 illness) 2. URT / Pharyngitis	ENT opin

Med itals

Mr.ARUN KUMAR.V
32/Male/MHC202403574
23/01/2024/IPC2024000216
Dr.ARTHI

GRAPHIC (T.P.R.) CHART

Name	Age	MRD No.

DATE							
No. of DAYS							
DAYS POST OP.							
TIME	6 AM	6 PM					

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
SPUTUM	—
WEIGHT	—
BATH	Given

Medway JS
The way to
(A Unit of United Allie
No.70, Kanchipuram Hi
Phone : 2742

Mr.ARUN KUMAR.V
32/Male/MHC202403574
23/01/2024/IPC2024000216
Dr.ARTHI

NAME :

D.O.A. :

D.O.D. :

I.P. No. : Age : Sex :

TREATMENT CHART

Consultants(s) :

S.No.	Drug Name	Strength Mg.	Frequency Route	Any Special Instruction
1.	INJ: XONE	1g	IV BD	
2.	INJ: PAN	40mg	IV BD	
3.	INJ: EMESET		IV BD	

Laboratory Test Result

Patient Name	:	**Mr.ARUN KUMAR**	Patient Id	:	MHC202403558
Visit No	:	DG202401063	Sample ID	:	CMWho21683
Age	:	30	Order Date	:	23/01/2024
Gender	:	Male	Collection Date & Time	:	23/01/2024 12:11:05PM
Visit Type	:	Diagnostics	Receiving Date & Time	:	23/01/2024 12:11:16PM
Patient Ph No	:	9894078454	Report Date & Time	:	23/01/2024 12:13:50PM
			Doctor Name	:	Dr.MEDWAY JSP CASUALTY

Investigation	Value	Unit	Biological Reference Value
HAEMATOLOGY			
CBC			
TWBC	18500	Cells/cu mm	4000 - 10000
(Method : *Flow cytometry by laser)*			
(Specimen : *Whole blood)*			
NEUTROPHILS	70	%	40 - 80
(Method : *Flow cytometry by laser)*			
(Specimen : *Whole blood)*			
LYMPHOCYTES	26	%	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	17.2	g/dL	13 - 17

Dr.Monica Kumbhat.,

LAB DIRECTOR

VIJAYALAKSHMI

Result Entered By

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

Patient Name :	**Mr.ARUN KUMAR**	Patient Id	: MHC202403558
Visit No :	DG202401063	Sample ID	: CMWho21683
Age :	30	Order Date	: 23/01/2024
Gender :	Male	Collection Date & Time	: 23/01/2024 12:11:05PM
Visit Type :	Diagnostics	Receiving Date & Time	: 23/01/2024 12:11:16PM
Patient Ph No :	9894078454	Report Date & Time	: 23/01/2024 12:13:50PM
		Doctor Name	: Dr.MEDWAY JSP CASUALTY

Investigation	Value	Unit	Biological Reference Value
(Method : *Colorimetric)* (Specimen : *Whole blood)* **HAEMATOCRIT**	51.2	%	40 - 50
(Method : *Calculated)* (Specimen : *Whole blood)* **TRBC**	5.2	Millions/cu mm	3.8 - 4.8
(Method : *Electrical Impedence)* (Specimen : *Whole blood)* **MCV**	98.2	fL	83 - 101
(Method : *Calculated)* (Specimen : *Whole blood)* **MCH**	30.7	pg	27 - 32
(Method : *Calculated)* (Specimen : *Whole blood)* **MCHC**	33.8	g/dL	31.5 - 34.5
(Method : *Calculated)* (Specimen : *Whole blood)* **PLATELET**	2.84 LAKHS/CUMM	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

VIJAYALAKSHMI

Result Entered By

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

Patient Name	:	**Mr.ARUN KUMAR**	Patient Id	:	MHC202403558
Visit No	:	DG202401063	Sample ID	:	CMSer21682
Age	:	30	Order Date	:	23/01/2024
Gender	:	Male	Collection Date & Time	:	23/01/2024 12:11:05PM
Visit Type	:	Diagnostics	Receiving Date & Time	:	23/01/2024 12:11:16PM
Patient Ph No	:	9894078454	Report Date & Time	:	23/01/2024 12:13:50PM
			Doctor Name	:	Dr.MEDWAY JSP CASUALTY

Investigation	Value	Unit	Biological Reference Value
DENGUE - NS1 (FIA)	0.06		COI : <1.0 NEGATIVE >1.0 POSITIVE
(Method :) (Specimen : *Serum)*			
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

VIJAYALAKSHMI

Result Entered By

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

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

(24 HOURS - MULTISPECIALITY HOSPITAL)

I.D. No. Mr.ARUN KUMAR
Patient's Name 30/Male/MHC202403558
Age / Sex Date of Reg : 23/01/2024 11:08 AM
Address

Date : 23/01/24

Temp : 101°F
PR : 82/m
BP : 110/70mmHg
Height :
Weight :
SpO2 :- 98% @RA

Chief Complaints : c/o coloured cough & Fever spike } 2 days
Relevant past History (if any) : c/o throat pain 2 days } 2 days
c/o Blocked Nose, Cough 2 days

Diagnosis :

Investigations : CBC, CRP, Dengue NS1Ag, Widal Test

S.No.	Drug Name	Dose	Before / After Food	Morning	Afternoon	Night
1.	Inj. Para	1g	Ivstat			

Other Advice :

23/01/24

No.70, Kanchipuram High Road, Chengalpattu - 2.
Phone : 2742 6829, 2742 8851