

**RETURN COMPLETED
FORM IN PROVIDED
POSTAGE PAID ENVELOPE**



Z330424 Rev. 01



HERITAGE HEALTH INSURANCE TPA PVT. LTD.

CHECK LIST

Scan Done By.....

2

Date.....

07/06/23

Name of the Patient CHANDANA GUPTA
Proposer Name SUDIPTA GUPTA
Policy Number 100600502210015846 CCN: HH112402016
Claim Type Cash Less Doc Rec. Date: 06/06/2023
Claim Value 26000.00 No of Pages: 1
Illness RIGHT EYE CATARACT

Sl. No.	Particulars	Y/N	Original/Photo Copy	Remarks
1	Claim form/Pre-auth form duly filled in and signed by the Insured/Agent	Y	Original	CLAIM FORM,PART C,PART D,PPN DECLARATION FORM
2	Intimation through mail/fax/courier	N	N/A	
3	No of days delay in claim submission: (Difference between final discharge date and claim submission date (-) 30)	N	N/A	
4	Delay condonation	N	N/A	
5	Policy Copy	N	N/A	
6	Photo ID proof	Y	Photo copy	
7	Advice for admission	N	N/A	
8	Original discharge summary	Y	Original	STICKER WITH IMPLANT CARD
9	Death certificate (P)	N	N/A	
10	Original prescription	N	N/A	
11	Original final bill	Y	Original	BILL OF SUPPLY
12	Original money receipt/cash memo	N	N/A	
13	Investigation reports in original	N	N/A	
14	Treatment sheet / History sheet	N	N/A	
15	Original fit-certificate	N	N/A	
16	Neft detail including cancelled cheque	N	N/A	
17	Email ID / Phone no.	N	N/A	

DATE: 03.06.2023



TO

Heritage Health Insurance TPA PVT Ltd
2 Hare Street
Nicco House
5th Floor
Kolkata

PAN NO: AAECA5407E
GSTIN: 19AAECA5407E1ZY

Dear Sir,

Thanking you for the confidence you have shown by availing our facilities. We hope we could meet your expectation. In case of any query about our report or service, please feel free to contact us.

Please ensure to provide the Bill No/Ref.No along with your payment details. Payment should be made by A/C Payee cheque in favour of **APOLLO MULTISPECIALITY HOSPITALS LTD**, payable at Kolkata.

CLAIM ID	BILL NO	BILL DATE	PATIENT NAME	BILL AMOUNT
HH112402016	AG,C-OCR-37354	31-MAY-2023	Mrs. CHANDANA GUPTA	26,000.00
			TOTAL -	26,000.00

(Rupees Twenty Six Thousand Only)

Thanking you and assuring our best attention all the times.
Regards

For **Apollo Medical Centre**, Kolkata



For collection / payment enquiries, please contact Mr. Sambhunath Pal at 9804000182. For Billing enquiries, please contact Mr. Tamal Mazumder. 9733815270/6289174190



Apollo Multispeciality Hospitals Limited

(Formerly Apollo Gleneagles Hospital Limited), 58, Canal Circular Road, Kolkata, West Bengal - 700 054, India.

+91-33-4420 2122 / 2320 3040 / 2320 2122, Emergency 1066 CIN:U33112WB1988PLC045223

Gariahat Clinic: 48/1F, Leela Roy Sarani (Gariahat), Kolkata, West Bengal - 700 019, India. +91-33-2461 8028 / 8079 / 8451 / 8547 / 9482

fokalkata@apollohospitals.com kolkata.apollohospitals.com



- ApolloMultispecialityHospitals
 apollomultispecialityhospitals
 Apollo_Kolkata
 Apollo Multispeciality Hospitals

DISCHARGE SUMMARY

Patient Name : Mrs. Chandana Gupta	Age/Sex : 63 Years/Female
UHID NO : 374730	Date of Admission : 31.05.2023
Date of Operation : 31.05.2023	Date of Discharge : 31.05.2023
Surgeon : Dr. Bikas Bhattacharyya	Bed No : DC- 5

Final Diagnosis:

Advanced Immature Cataract in Right eye

Reasons For Admission(Chief Complaints):

Visual recovery.

Significant Findings:

Adv. Immature Grade IV Cataract.

Procedure Performed:

Phaco with Tecnis Eyhance IOL in Right eye under topical anaesthesia.

Brief Course In The Hospital:

Uneventful and satisfactory.

Condition at discharge:

Haemodynamically stable.

Discharging advice:

1. Rest.
2. **REMOVE EYEPAD TOMORROW MORNING.**
3. Do not sleep on the operated side for 1 week.
4. Diet- Usual.
5. Do not shower for 7 days.
6. You may read and watch TV from today.
7. You may brush your teeth, comb your hair and move around your house from today.
8. Pan 40 – 1 cap once before food ,if pain occurs.
9. Calpol 650mg - 1 tab once after food, if pain occurs.
10. You have an appointment with me at 07.06.2023 at 3.30 P.M at Apollo Medical Centre.
11. MYTICOM/ Predmet /Predforte eyedrop -1 drop 6 times daily Right eye x 2 weeks then, 1 drop 4 times daily in Right eye x 2 weeks
12. To wear dark glasses at day time and eye guard during sleep x 1 week.
13. Vigamox eye drop -1 drop 3 times daily in Right eye x 4 days.
14. Tear drops eye drop – 1 drop 3 times daily in Both eyes from tomorrow x 1 month.
15. DUVET eye wipes for cleaning.



If there are following symptoms/signs, please contact your consultant or in emergency 1066(Toll Free) Tempt. > 100° F, Persisting bleeding, excruciating pain/ severe swelling around the wound.

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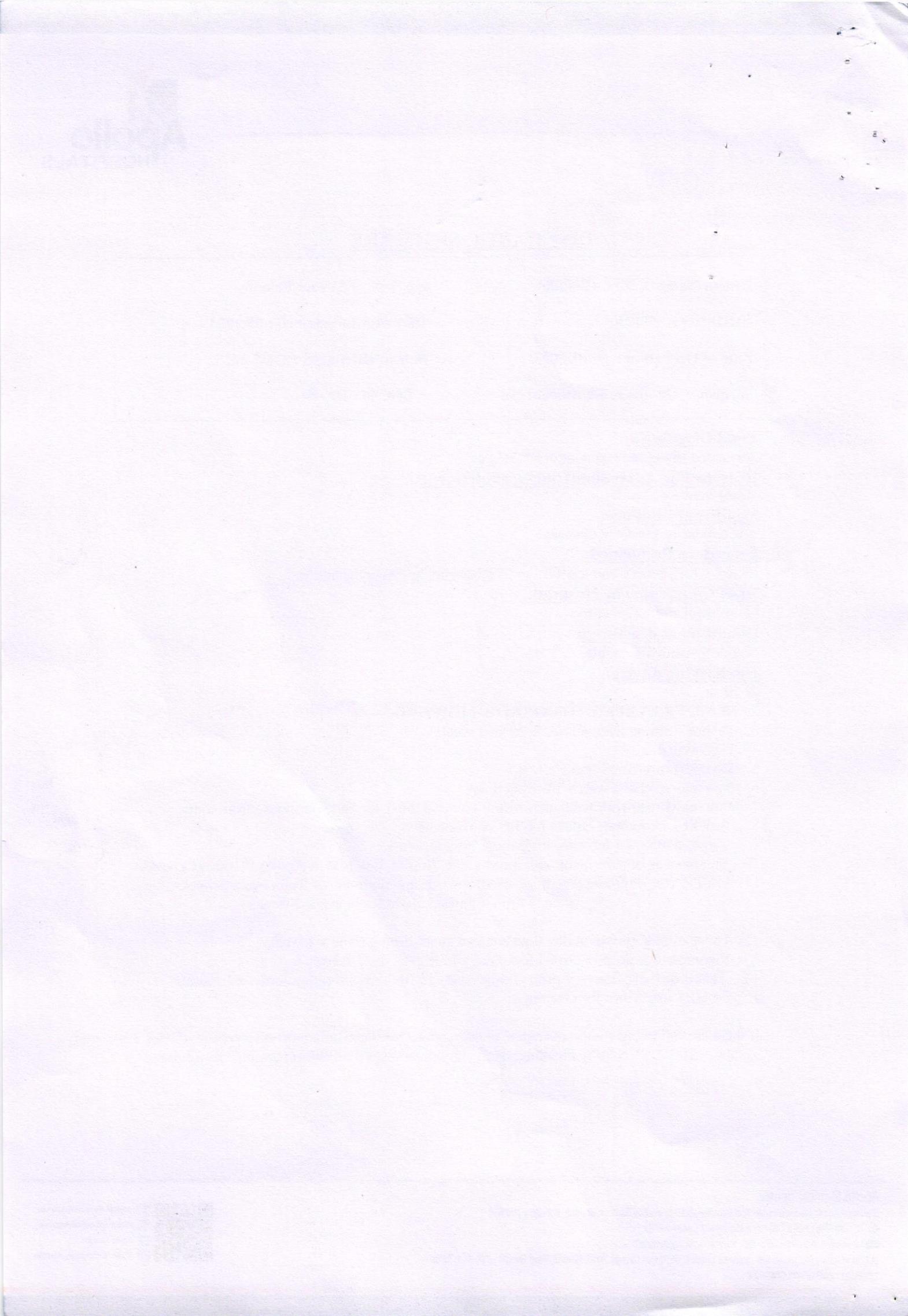
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CIN:U33112WB1988PLC045223





GSTIN: 19AAECA5407E1ZY

OP Credit - Bill of Supply

Reference No :

Name	: Mrs. CHANDANA GUPTA	Age: 63Yr 0Mth 6Days	UHID	AGMC.0000374730
		Sex: Female		
Guardian	: SELF			
Name Address	: 11 CENTRAL PARK JADAVPUR KOL-32 Kolkata West Bengal India 000000, CellNo:91-9433076660		OP Number:	AGMCOPP426949
Doctor's Name	: Dr. BIKAS BHATTACHARYA		Bill No :	AGMC-OCR-37354
Speciality	: OPHTHALMOLOGY		Date :	31-May-23
Payer Name(1)	: HERITAGE HEALTH SERVICES PVT LTD AGREEMENT		Time :	15:06:09
Ref No	: ---			
Authorization No	:			
Employer Name	: HERITAGE HEALTH INSURANCE TPA PVT LTD			



Barcode for OP Number AGMCOPP426949

Bill Amount: ₹. 42,700.00

FOR APOLLO MULTI SPECIALITY HOSPITALS

Amount in words: ₹ Forty-Two Thousand Seven Hundred Only

S.Nc	Aliascode	Service Type/ServiceName	Department	Qty	Amount (INR)
1		Consumables(999311)			
1		EYHANCE	Ophthalmology	1	10,700.00
				Sub Total	10,700.00
2		Package Charges(99931)			
1		MICS 2.2MM PRELOADED LENS (EXCLUDING LENS)	Ophthalmology	1	32,000.00
				Sub Total	32,000.00

Service Amount :	42,700.00
Total Bill Amount	42,700.00
Authorization Amount(1) HERITAGE HEALTH SERVICES PVT LTD AGREEMENT	26,000.00
To Pay (Cash:16,700.00, NonCash:0.00)	16,700.00
Net Amount	26,000.00

No Tax Is Payable on Reverse Charge Basis

(QR) Denotes Quick Registration

Authorized Signatory

* Denotes Cancelled Services

Ms. Kasturi Pathak Sengupta

Cashier

Signature Of Patient/Attendant

Relationship with Patient :

DESCRIPTIONS



Page 1 of 1

**KINDLY NOTE: IT IS MANDATORY TO BRING YOUR ORIGINAL BILL FOR COLLECTING THE REPORTS.
PLEASE COLLECT THE REPORT WITHIN 3 MONTHS**

Apollo Medical Centre

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CIN:U33112WB1988PLC045223

GST IN:19AAECA5407E1ZY

INPATIENT BILL

Name : Mrs.Chandana Gupta	UHID :374730
AGE/SEX :63/Female	Doctor :Bikas Bhattacharya
DOA: 31.05.2023	DOS: 31.05.2023
DOD: 31.05.2023	Bill No:AGMC-OCR

Package Name ::- Tecnis Eyhance	MICS 2.2MM PRELOADED LENS
Room Rent	1,500
Operation Theatre Charges (1/2 - 1 hrs)	5500
Surgeons Fee	18,000
Anasthesists Fee	1,000
OT Consumables & Medicines	6,000
Lense Cost	10700
Package Total	42,700
TPA APPROVED	26000

Received with thanks from Mrs. Chandana Gupta the amount of Rs 16700/-only.

*Chandana
Stab curd
31-05-2023*

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CIN:U33112WB1988PLC045223



OT & Ward Consumables, Medicines Bill Break-up in package

Patient Name: Mrs.Chandana Gupta		Surgeon : Dr.Bikas Bhattacharya		
UHID :374730		Surgery Name : Phaco		
Sex :Female		Date : 31.05.2023		
Sl.No	Item Description	Unit	Qty Used	Price
1	B T Set	pcs	1	170
2	Disposable Syringe 20ml	pcs	2	15.5
3	Disposable Syringe 10ml	pcs	4	8.5
4	Disposable Syringe 5ml	pcs	3	5.9
5	Disposable Needles	pcs	3	2
6	Ocucut LTST 15	pcs	1	165
7	Ocucut LTST 16	pcs	1	155
8	Ocucut CRBU	pcs	1	750
9	Eye Drape polly 700	pcs	1	36
10	Eye Dress ED8	pcs	1	420
11	Disposable Surgens Cap	pcs	2	18
12	Disposable Surgens Mask	pcs	2	15
13	Pulse Oximeter		1	1100
14	Inj. Decadron	vial	1	29
15	Inj.2% Xylocaine Adrenalin	amp	1	40
16	Inj.Occulan	amp	2	15
17	Gauze	pcs	10	3
18	Inj.Adrenaline 1ml	amp	2	6
19	Venflown 20 gm	pcs	1	120
20	Disposable Sterile Gloves	Pair	4	45
21	Inj. Hynidase	Vial	1	86.75
22	Inj.Auroblue	vial	1	110
23	Viscomet PF	pcs	2	160
24	Surgeon Blade	pcs	1	30
25	Inj.Zofer 4mg	amp	1	20
26	Paper Gown(sterile)		2	750
27	ECG Electrodes	pcs	4	10
28	Disposable cannula	pcs	1	10
29	Plain Towel (303)	pcs	2	245.5
	Total Bill Amount			6000



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CIN:U33112WB1988PLC045223



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Apollo_Kolkata

Apollo Multispeciality Hospitals

(O)

Cashless Authorization Letter

(Part-D)

Claim Number: HH112402016 (Please quote this number for all further correspondence)

Date: 26/05/2023

Authorization is valid for admission up to 10/06/2023

Hospital Name	: APOLLO MEDICAL CENTRE (KOLKATA)	Name of the Insurance Company	: National Insurance Company
Address	: 48/1F, Leela Roy Sarani, Ballygunge, KOLKATA; West Bengal Pin : 700019	Name of TPA Proposer Name Patient's Member ID/TPA/Insurer Id of the Patient:	: Heritage Health Insurance TPA Pvt. Ltd. : SUDIPTA GUPTA : HHS1.0146643424
Rohini ID	: 8900080233720	Relation with Proposer	: Wife

Dear Sir / Madam,

This has reference to the pre-authorization request submitted on 26/05/2023 .We hereby authorize cashless facility as per details mentioned below:

Patient Name	: CHANDANA GUPTA	Age : 62 Years	Gender : F
Policy Number	: 100600502210015846	Expected Date of Admission	: 31/05/2023
Policy Period	: 29/01/2023 To 28/01/2024	Expected Date of Discharge	: 31/05/2023
Room category	: General Bed	Estimated length of stay :	1
Eligible Room	: PRIVATE		
Category as per T&C of Policy Contract			
Provisional Diagnosis	: RIGHT EYE CATARACT	Proposed line of treatment	: RIGHT EYE CATARACT

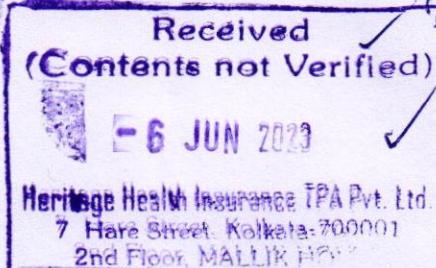
Authorization Details :-

Date & Time	Reference Number	Amount	Status
26/05/2023 - 16:08	HH112402016	26000.00	Approved

Total Authorized amount:- Rs. Twenty-Six Thousand Only (In Words)

Authorization Remarks :

PLEASE PROVIDE "PATIENT LENS IMPLANT IDENTIFICATION CARD" ALONG WITH THE STICKER AND TAX INVOICE.



Hospital Agreed Tariff :-

- I. Package Case
- II. Non-package Case
 - i. ROOM RENT/DAY
 - ii. ICU RENT/DAY
 - iii. NURSING CHARGES/DAY
 - iv. CONSULTANT VISIT CHARGES/DAY
 - v. SURGEON FEE/OT/ANESTHETIST
 - vi. OTHERS (specify)

Authorization Summary :-

Total Bill Amount	:(INR)
Deductions Detail	:(INR)
Discount	:(INR)
Co-Pay	:(INR)
Deductibles	:(INR)
Total Authorised Amount	:(INR)
Amount to be paid by Insured	:(INR)

Total Deduction Details :-

S. no.	Description	Bill Amount	Deducted Amount	Admissible Amount	Deduction Reason
1	Room Rent	1000	1000	1000	Standard Deduction

ADMISSION ADVICE

NAME: Chondro, Jyoti Age: 43 Sex: Female

Phacoemulsification with PCIOL in RIGHT / LEFT EYE on 31/05/2023

Apollo Medical Centre, Gariahat, kolkata .

1. Vigamox eyedrop 1 drop 4 times a day in both eyes from

28/05/2023

2. On the day of operation (31/05/2023),

Do Normal breakfast/ Light lunch.

Tropicacyl Plus eyedrop 1 drop at 15 min interval on Right eye/ Left eye from

10 Am

Report at Apollo Medical Centre 2nd floor reception at 11-30 Am

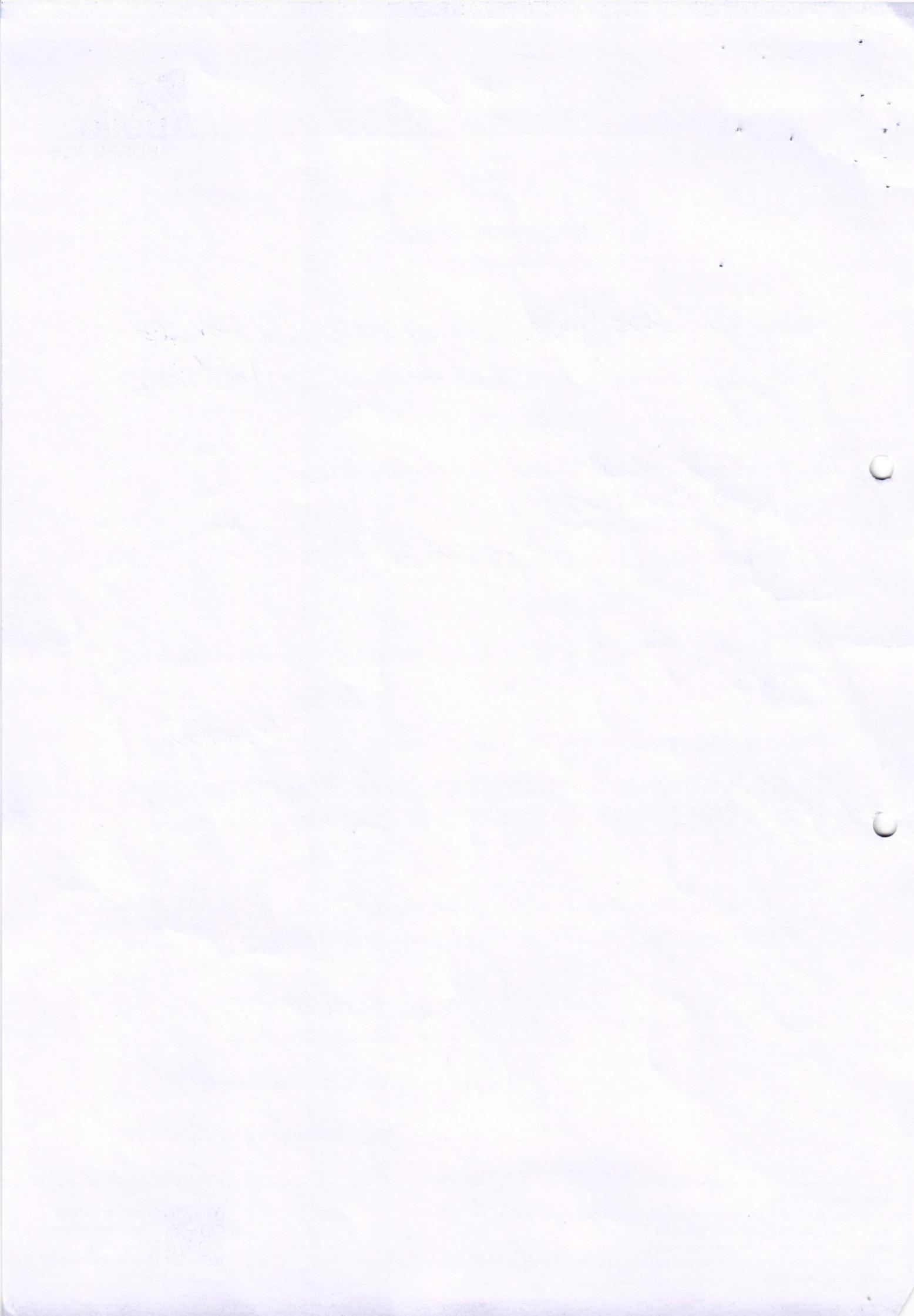
*****PLEASE BRING COVID RT-PCR REPORT/ VACCINE FINAL DOSE CERTIFICATE ON THE DAY OF SURGERY**

- Please continue all other systemic medicine as advised.
- Stop blood thinners before and after surgery after the doctor permission

Bikas Bhattacharya
(.....)

Dr.Bikas Bhattacharya

Regn no: 41712 WBMC
**KINDLY NOTE: IT IS MANDATORY TO BRING YOUR ORIGINAL BILL FOR COLLECTING THE REPORTS.
PLEASE COLLECT THE REPORT WITHIN 3 MONTHS**



TO WHOM IT MAY CONCERN

**Sub: Patient (Mrs. Chandana Gupta) regarding submission of original Invoice of
Implant/Sticker**

Dear Sir/Madam,

This has reference to your queries with regard to submitting original tax Invoice for Lens used to the patient at our Medical Centre. You are aware the Apollo Hospital Group has adopted uniform material management policy and as such the purchases of any Lens are made through Central Purchase Unit (CPU) at Hyderabad for all its group hospitals. Hence the invoicing of the same is done for the entire group and as such providing original Invoice of each Lens is not possible.

However it may please be noted that we provide original stickers along with our bills that are submitted to you which provided details of lens used.

We hope we have been able to satisfy your queries and would request you to release the payment at the earliest.

Thanking you

Yours truly

For Apollo Medical Centre, Kolkata

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Apollo Medical Centre

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(A Unit of Apollo Multispeciality Hospitals Limited) 58, Canal Circular Road, Kolkata, West Bengal - 700 054, India.

CIN:U33112WB1988PLC045223



374730



IRDAI License No. 008

**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: **Heritage Health Insurance TPA Pvt Ltd**
- b. Toll free phone number: **1800 345 3477**
- c. Toll free fax: **033 4055 7660**
- d. Name of Hospital: **Apollo Medical Centre**
i. Address **48/1F, Leela Roy Sarani, KOL-19**
- ii. Rohini ID _____
- iii. e-mail ID **oagsec_agh@apollohospitals.com**

TO BE FILLED BY INSURED/PATIENT

CHANDANA GUPTA.

- A. Name of the Patient: _____
- B. Gender: Male Female Third Gender
- C. Age: _____ Years _____ Month
- D. Date of Birth: **08 DD 10 MM 1960 YYY**
9433076660 / 8240083403
- E. Contact number: **94330-76660**
- F. Contact number of attending Relative: **HHSI-0146643424**
- G. Insured Card ID number: _____
- H. Policy number/Name of Corporate: _____
- 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 Bikas Bhattacharya
- B. Contact number:
- C. Nature of Illness/Disease with presenting complaint: VISION IN (R) Eye
- D. Relevant Critical Findings: As per prescription
- E. Duration of the present ailment 120 Days
- i. Date of First consultation: _____ DD _____ MM _____ YYYY
- ii. Past history of present ailment, if any: _____
- F. Provisional diagnosis: Cataract in (R) Eye
- i. ICD 10 code: _____
- G. Proposed line of treatment:
- i. Medical Management ()
ii. Surgical Management (✓)
iii. Intensive care ()
iv. Investigation ()
v. Non-allopathic treatment ()
- H. If investigation and/or Medical Management, provide details: _____
- i. Route of Drug Administration: _____
- I. If surgical, name of surgery: Phaco Surgery in (R) Eye
- 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 31 DD 05 MM 23 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 0 Days
- F. Days in ICU _____ Days
- G. Room Type Daycare
- 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 42,700/-

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 Bikas Bhattacharya

b. Qualification:

41712-CBMC

c. Registration number with state code

APOLO MEDICAL CENTRE
48/1F, LEELA ROY SARANI, KOLKATA - 700019
CE LICENCE NO- 34235670
VALID UPTO- 29-12-2025

Hospital Seal
(Must include Hospital ID)

Patient/Insured Name and Signature

CHANDANA GUPTA
Chandana Gupta.

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: CHAN DANA GUPTA

b) Contact number: 94330 76660 c) e-mail Id (optional) _____

d) Patient's / Insured's Signature: Chandana Gupta

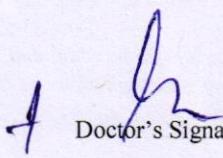
Date: 25-05-23 Time: 1:00 PM

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 expect 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
APOLLO MEDICAL CENTRE
48/1F, LEELA ROY SARANI, KOLKATA - 700019
CE LICENCE NO- 34235670
VALID UPTO- 29-12-2025

 Doctor's Signature

Date:

Time:

2025


ভারতের নির্বাচন কমিশন
পরিচয় পত্র
ELECTION COMMISSION OF INDIA
IDENTITY CARD

SCG3128113



নির্বাচকের নাম : সুদীপ্তা গুপ্তা

Elector's Name : Sudipta Gupta

পিতার নাম : সত্যাভুষন গুপ্ত

Father's Name : Satyabhushan
Gupta

লিঙ্গ/Sex : পুরুষ / M
জন্ম তারিখ : XX/XX/1955

Date of Birth

SCG3128113

ঠিকানা:
সেন্ট্রাল পার্ক, কোলকাতা মিউনিসিপাল
কর্পোরেশন, যাদবপুর, কলকাতা-700032

Address:

CENTRAL PARK, KMC, JADAVPUR,
KOLKATA-700032


Date: 02/03/2020

150 - যাদবপুর নির্বাচন ক্ষেত্রের নির্বাচক নিবন্ধন
আধিকারিকের স্বাক্ষরে অনুমতি

Facsimile Signature of the Electoral
Registration Officer for
150 - Jadavpur Constituency

ঠিকানা পরিবর্তন হলে নতুন ঠিকানায় ভোটার লিস্টে নাম
ঢেকা ও একই নথির নতুন সার্টিফিকেট পাওয়ার
জন্য নির্বাচক কর্মসূচি এই পরিচয়পত্রের নথিপত্র উপরে করুন।

In case of change in address mention this Card No.
in the relevant Form for including your name in the
roll at the changed address and to obtain the card
with same number

183 / 113



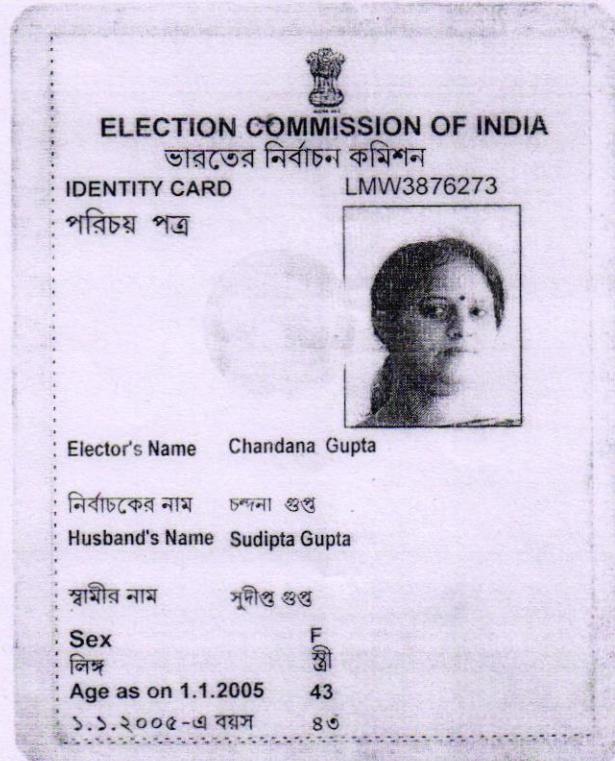


इस कार्ड के छोने / पाने पर कृपया सुधित करें / लौटाएँ:
आयकर वैन सेवा इकाई, इन एस डी एल
तीसरी मंजूल, सफायत चैबर्स,
बानेर टेलिफोन एस्ट्रेंजे के नजदीक,
बानेर, पुणे - 411 045.

If this card is lost / someone's lost card is found.
please inform / return to :

Income Tax PAN Services Unit, NSDL
3rd Floor, Sapphire Chambers,
Near Baner Telephone Exchange,
Baner, Pune - 411 045.

Tel: 91-20-2721 8080, Fax: 91-20-2721 8081
e-mail: tininfo@nsdl.co.in



Address:
11 Central Park 102 Jadavpur South 24 - Parganas
700032

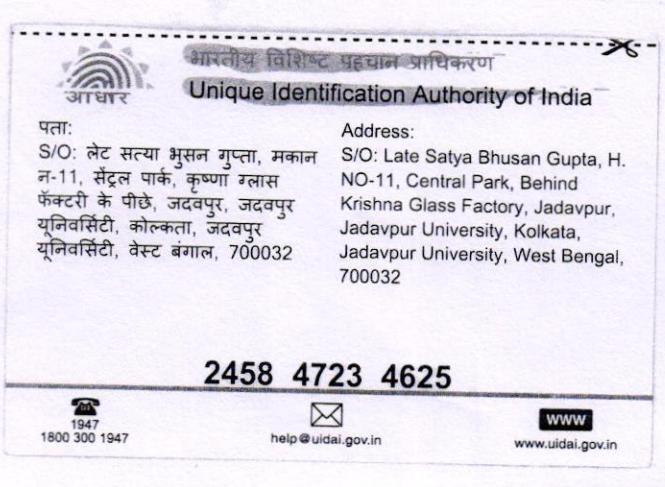
ঠিকানা :
১১ সেন্টাল পার্ক ১০২ যাদবপুর দক্ষিণ ২৪ পৰগণা ৭০০০৩২

Facsimile Signature
Electoral Registration Officer
নির্বাচন নিবন্ধন আধিকারিক

Assembly Constituency: 108-Jadavpur

বিধানসভা নির্বাচন ক্ষেত্র : ১০৮-যাদবপুর
District: South 24 - Parganas জেলা: দক্ষিণ ২৪ পৰগণা
Date: 10.03.2005 তারিখ: ১০.০৩.২০০৫

112/0018



आयकर विभाग
INCOME TAX DEPARTMENT



भारत सरकार
GOVT. OF INDIA



स्थायी लेखा संख्या कार्ड
Permanent Account Number Card

ADJPG8596M

नाम / Name
SUDIPTA GUPTA

पिता का नाम / Father's Name
SATYA BHUSAN GUPTA

जन्म की तारीख / Date of Birth
23/12/1954

हस्ताक्षर / Signature



28/07/2017

इस कार्ड के खोने / पाने पर कृपया सूचित करें / लौटाएँ:
आयकर पैन सेवा इकाई, एन एस डी एल
५ वी मंजिल, मंत्री स्टर्लिंग, प्लॉट नं. 341, सर्वे नं. 997/8,
मॉडल कालोनी, दीप बंगला चौक के पास,
पुणे - 411 016.

If this card is lost / someone's lost card is found,
please inform / return to :
Income Tax PAN Services Unit, NSDL
5th floor, Mantri Sterling,
Plot No. 341, Survey No. 997/8,
Model Colony, Near Deep Bungalow Chowk,
Pune - 411 016.

Tel: 91-20-2721 8080, Fax: 91-20-2721 8081
e-mail: tininfo@nsdl.co.in

पॉलिसी नंबर/ Policy Number:
100600502110008915

व्यवसाय स्रोत/Business Source: 100600

जारीकर्ता कार्यालय/Issuing Office

कार्यालय कोड /Office Code: 100600
कार्यालय पता /Office Address: KOLKATA
DIVISION VI First Floor, National Insurance
Building, 8, India Exchange Place, Kolkata, -
700001.

राज्य कोड/State Code: 19, West Bengal
जीएसटीआइन/GSTIN: 19AACN9967E1Z0
संपर्क संख्या/Contact Number: 33 22209299
मोबाइल नंबर/Mobile Number: 0

विक्रय चैनल विवरण/Sales Channel Details:

विक्रय चैनल कोड/Sales Channel Code:
10060090000016101

नाम /Name: Mr Arun Kumar Sahoo संपर्क
संख्या/Contact Number: 9433246793
सह दलाल कोड /Co Broker Code:

Product UIN No: NICLIP21558V062021

कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free
Number: 1800 345 0330
ईमेल/email: customer.support@nic.co.in

नेशनल इन्�श्योरेन्स
National Insurance

Trusted Since 1906



ग्राहक का नाम /Customer Name: DR SUDIPTA GUPTA

ग्राहक आईडी /Customer ID:
9512841386

पैन /PAN: ADJPG8596M

पता/ Address: 11, CENTRAL PARK, BEHIND KRISHNA GLASS
FACTORY, JADAVPUR, DIST.: KOLKATA, WEST BENGAL, शहर/
City: KOLKATA, ज़िला/District: KOLKATA, राज्य/State: WEST BENGAL,
पिन/PIN: 700032.
सेल/Cell: 9433076660

आधार /AADHAR:

फोन /Phone: 9433076660

ई-मेल /E-Mail: sudiptagupta54@gmail.com

पॉलिसी प्रभावी होने का समय घंटे को Policy Effective from 00:00 hours, on 29/01/2022 की मध्य रात्रि तक प्रभावी/to midnight of
28/01/2023

प्रीमियम/ Premium	₹ 52,175.00	कवर नोट संख्या और तिथि / Cover Note Number and Date	लागू नहीं /NA
Less:Digital Discount	₹ 0.00		
Total Premium	₹ 52,175.00		
सीजीएसटी/CGST	₹ 4,696.00		
एसजीएसटीयूटीजीएसटी/ SGST/UTGST	₹ 4,696.00	प्रस्ताव संख्या और तिथि/ Proposal Number and Date	8800220106162568 दिनांक/Dt. 06/01/2022
आईजीएसटी/IGST	₹ 0.00		
केरला बाढ़ उपकर/Kerala Flood Cess	₹ 0.00		
कम:जीएसटी_टीटीएस / Less:GST_TDS	₹ 0.00		
वसूली धोय योग्य स्टाम्प छूटी /Recoverable Stamp Duty	₹ 0.00	रसीद संख्या और तिथि/ Receipt Number and Date	100600812110012485 दिनांक/Dt. 06/01/2022
कुल :प्रीमियम /Total Amount	₹ 61,566.00	पिछली पॉलिसी संख्या और समाप्ति तिथि / Previous Policy Number and Expiry Date	101901502010008246दिनांक/Dt.28/01/2022 101901501910008782दिनांक/Dt.28/01/2021 101901501810009117दिनांक/Dt.28/01/2020 101901501710008883दिनांक/Dt.28/01/2019 101901501610005715दिनांक/Dt.28/01/2018

(रुपए/Rupees Sixty One Thousand Five Hundred Sixty Six केवल/Only.)

*सरकारी स्विस्टी Government
Subsidy: ₹ 0.00

बीमित व्यक्ति का विवरण/ Details of Insured Persons

क्र.सं./ S.No	बीमित व्यक्ति का नाम/ Name of the Insured Person	जन्म-तिथि/ आयु/ Date of Birth Age	संबंध पेशा/ RelationOccupation	लिंग/ Gender	बीमा राशि (₹.) सीधीराशि/ Sum Insured(₹) CB Amount(₹)	पहले से मौजूद रोग/ अपवर्जन Pre- existing Diseases/Exclusi- ons
1	SUDIPTA GUPTA	22/12/1954 67	Self All - Occupation	M	3,00,000.00 1,40,000.00	NA
2	CHANDANA GUPTA	06/10/1960 61	Wife Housewife	F	3,00,000.00 1,40,000.00	NA

वैकल्पिक कोरीराइट विवरण /Optional Copayment details :-

सह भुगतान/co payment %:NA

नामांकित विवरण /Nominee Details

नामांकित व्यक्ति का नाम/ Name of the Nominee
SAYAN GUPTAबीमित व्यक्ति के साथ संबंध/ Relationship with Insured
Son

Frequency of Premium Payment: Annual

एफ1/

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड

National Insurance Company Limited

CIN U10200WB1966PLC000713D80A Reg. No. 58 by ID: 66927

पंजीकृत एवं प्रधान कार्यालय: 3 मिडिलटन स्ट्रीट कोलकाता 700 071
Registered & Head Office: 3 Middleton Street, Kolkata-700 071

Ph. : 033-2283 1705-06, email : website.administrator@nic.co.in

पॉलिसी नंबर /Policy Number:

100600502110008915

जारीकर्ता कार्यालय/Issuing Office

कार्यालय कोड /Office Code: 100600

कार्यालय पता /Office Address: KOLKATA

DIVISION VI First Floor, National Insurance Building, 8, India Exchange Place, Kolkata, - 700001.

राज्य कोड/State Code: 19, West Bengal

जीएसटीआईन/STIN: 19AACN9967E1Z0

संपर्क संख्या/Contact Number: 33 22209299

मोबाइल नंबर/Mobile Number: 0

व्यवसाय स्रोत /Business Source: 100600

विक्रय चैनल विवरण/ Sales Channel Details

विक्रय चैनल कोड/ Sales Channel Code:

100600900000016101

नाम/Name: Mr Arun Kumar Sahoo

संपर्क संख्या/Contact Number: 9433246793

सह दलाल कोड/ Co Broker Code:

Product UIN No: NICLIP21558V062021

कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free

Number: 1800 345 0330

ईमेल/email: customer.support@nic.co.in

टीपीए का विवरण/ TPA Details: HERITAGE HEALTH TPA PVT LTD - KOLKATA CRO I, Fifth Floor, Nicco House, 2, Hare Street, Kolkata - 700001 Contact No : 33 - 22486430 Email : hhsplaccounts@bajoria.in.

जिसकी गवाही में दिन/ माह /वर्ष को उपरोक्त उल्लिखित कार्यालय पते पर अधोहस्ताक्षरी को विधिवत अधिकृत किया जा रहा है उसके हाथ निर्धारित किए जाएं। यह अनुसूची, संलग्न पॉलिसी, खण्ड, पृष्ठांकन और पॉलिसी शब्दों, जो कंपनी वेबसाईट <https://nationalinsurance.nic.co.in> पर उपलब्ध है, को एक अनुबंध के रूप में एक साथ पढ़ा जाए तथा कोई भी शब्द या अभिव्यक्ति जिसके लिए यह विशेष अर्थ पॉलिसी या अनुसूची के किसी भी हिस्से में संलग्न किया गया हो, एक ही अर्थ वहन करेगा जाहे जहाँ भी उल्लिखित हो। यह आश्वासन दिया जाता है कि प्रीमियम चेक की अस्वीकृति के मामले में, यह दस्तावेज स्वतः आंंभ से ही निरस्त मानी जाएगी। */IN WITNESS WHEREOF, the undersigned being duly authorized hereunto set his/ her hand at the office address mentioned above, this 06/January/2022. This schedule, the attached policy, the clauses, the endorsements and policy wordings as available in the website <https://nationalinsurance.nic.co.in> shall be read together as one contract and any word or expression to which the specific meaning has been attached in any part of this policy or of the schedule shall bear the same meaning wherever it may appear. It is warranted that IN CASE OF DISHONOUR OF THE PREMIUM CHEQUE, THIS DOCUMENT STANDS AUTOMATICALLY CANCELLED 'AB-INITIO'*

इंश्योरेन्सइंडियालिमिटेड ओम्बडसमैन का विवरण/Ombudsman Details: Shri P. K. Rath, Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340, Fax : 033 - 22124341, Email: bimalokpal.kolkata@ecoi.co.in.

स्टांप रुपूटी
Stamp
Duty:
(₹ 0.50)

कृते नेशनल इंश्योरेन्स कंपनी लिमिटेड/

For and on behalf of National
Insurance Company Limited

अधिकृत हस्तात्करक्ती/ Authorized Signatory





GIPSA NETWORK-DECLARATION FORM
(To be filled by the Hospitals)

Name of the Hospital: Apollo Medical Centre Date of Admission: 31/05/2023
 Address: 48/1F, Leela Roy Sarani, Kt-19
 PATIENT NAME/INSURED NAME (BLOCK LETTERS): CHANDANA GUPTA AGE/SEX: 63yrs Female

(To be filled by the Insured/policy holder/Attendant)

1. Do you have an Insurance policy? YES/NO

If yes, then please select: New India/ United India/ National Insurance/ Oriental Insurance/others

Policy No: _____
 TPA Name: Heritage TPA
 TPA card No: _____

2. Have you contacted TPA or Insurance Company for cashless facility? YES/NO

3) Whether patient opted for Eligible Room Category under Policy: YES/NO

If No, then kindly mention the opted room category: Daycare

On my own option, I wish to avail above facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed tariff for the treatment. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed tariff for the treatment and balance amount will be borne by me / patient only.

I have also been explained that when room service of a category other than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me/ patient only

Signature: Chandana Gupta

Signature: P

Name of the Patient/Patient's attendant:

Name of the Hospital Representative & Hospital Seal:

APOLLO MEDICAL CENTRE

48/1F, LEELA ROY SARANI, KOLKATA - 700019

CE LICENCE NO - 34235570

Mobile No.: 94330-76660

E-Mail: sudiptagupta54@gmail.com

VALID Upto - 29-12-2020

PAN / Form 60: ADPAG8596M BBEPG133736

Aadhar Card Number: 2458-1723-1625 3078-7280-6625

Dr. S. K. Dutt
M.D., M.S.
Surgical & Medical
Centre
Swaran Kolkatta - 700011
Phone: 25625252
25625252-1122
25625252-1122-5088-1122

ON Blood Thinner Rx



Dr. Bikas Bhattacharya
 Senior Consultant Eye Surgeon
 MBBS (Hons.), MS, DO
 Former A.I.O.S. Research
 Fellow-L.V.Prasad Eye Institute (Hyderabad)
 Spl.In Phaco/Glaucoma/Cosmetic Surgery/Laser
 M: 94333702010/9674601578 (9 p.m to 10 p.m)
 e-mail: drbhattacharya_bikas@yahoo.co.in.
 drbhattacharya_bikas@gmail.com
 Regn No.: 41712

Systemic Hx

H+N+ for long

↓ DM+

Rx

Rx Allergy

NOT KNOWN.

AT < 16 mmHg

4.10 pm.

Tentative
28/03/2023

- Serum lipid profile
- urine for routine
- 3 F.R. (HIV, HBV & HCV)

BIOCHEMICAL BB
(Complaint)

KINDLY NOTE: IT IS MANDATORY TO BRING YOUR ORIGINAL BILL FOR COLLECTING THE REPORTS.

PLEASE COLLECT THE REPORT WITHIN 3 MONTHS

D

17.05.23

Mrs. Chandrani Gupta.

(63 yrs) 1F

CLO: (RLE) Black floaters seen since 6 Month.

(B1E) Itching since 2 yrs. | CRP (B1E)

PFTA < 6/18 ~ N12
4 yrs. | 6/19 ~ N6 | CRP (B1E)

Ref. < ± 1+2.00 DEX 180° - 6/12 P

AQD | B1E + 1.75 DS / + 0.75 DEX 20° - 6/19
+ 3.00 DS { N12
{ Feel same = PCP } N6

BB = Ad. Irritation Gland. R>L
= Few, no features of DR
involvement, abnl papillae w/w.

Rx = PVD

S1) Dr. Photo to record Rx → followed by Rx

- ① Blood Sugar (R.L.) 72780 20161
 - ② Blood Sugar (F)
 - ③ Hb A1C
 - ④ E.C.G.
 - ⑤ Hb %, TC, DC, BSL
- Pre Anesthesia Checkup



ApolloMultispecialityHospitals
apollomultispecialityhospitals
Apollo_Kolkata
Apollo Multispeciality Hospitals

7278020161

ADMISSION ADVICE

NAME: Chondro Gopal Age : 63 Sex: Female

Phacoemulsification with PCIOL in RIGHT / LEFT EYE on 31/05/2023

Apollo Medical Centre, Gariahat, kolkata .

1. Vigamox eyedrop 1 drop 4 times a day in both eyes from

28/05/2023

2. On the day of operation (31/05/2023)

Do Normal breakfast/ Light lunch.

Tropicacyl Plus eyedrop 1 drop at 15 min interval on Right eye/ Left eye from

10 Am

Report at Apollo Medical Centre 2nd floor reception at 11-30 AM

*****PLEASE BRING COVID RT-PCR REPORT/ VACCINE FINAL DOSE CERTIFICATE ON THE DAY OF SURGERY**

- Please continue all other systemic medicine as advised.
- Stop blood thinners before and after surgery after the doctor permission

Drikas Bhattacharya
(.....)

Dr.Bikas Bhattacharya

Regn no: 41712 WBMC

KINDLY NOTE: IT IS MANDATORY TO BRING YOUR ORIGINAL BILL FOR COLLECTING THE REPORTS.
PLEASE COLLECT THE REPORT WITHIN 3 MONTHS

Apollo Medical Centre

(Formerly Apollo Gleneagles Medical Centre), 48/1F, Leela Roy Sarani (Gariahat), Kolkata - 700 019

+91-33-2461 8028 / 8079 / 8451 / 8547 / 9482 / 8483

info@apollohospitals.com www.kolkata.apollohospitals.com

(A Unit of Apollo Multispecialty Hospitals Limited) 58, Canal Circular Road, Kolkata, West Bengal - 700 054, India.

CIN:U33112WB1988PLC045223



ApolloMultispecialtyHospitals
 apollomultispecialtyhospitals
 Apollo_Kolkata
 Apollo Multispecialty Hospitals

Patient :GUPTA CHANDANA ✓
 Patient ID :943307660
 Date Of Birth :06/10/1960
 (dd/mm/yyyy)

Surgeon :BHATTACHARYA B
 Exam Date :17/05/2023 - 18:03
 (dd/mm/yyyy)

OD
Phakic

OS
Phakic

Data Measurements **n** : 1.3375

Aladdin Optical

AL : 23.12mm K1 : 43.16D @ 142°
 ACD : 2.98mm K2 : 43.39D @ 52°
 LT : 4.54mm CYL : -0.23D ax 142°
 CCT : 0.533mm AvgK : 43.28D
 WTW : 11.54mm

Data Measurements **n** : 1.3375

Aladdin Optical

AL : 23.03mm K1 : 42.80D @ 120°
 ACD : 2.91mm K2 : 43.59D @ 30°
 LT : 4.64mm CYL : -0.80D ax 120°
 CCT : 0.515mm AvgK : 43.20D
 WTW : 11.76mm

Target Refraction: 0

Target Refraction: 0

Alcon
SA60AT

Barrett Universal II	
IOL(D)	REF(D)
21.50	0.71
22.00	0.35
22.50	-0.01
23.00	-0.38
23.50	-0.75

IOL @ Target LF = 1.780
22.48 A = 118.800

AMO
Sensar AR40E

Barrett Universal II	
IOL(D)	REF(D)
21.50	0.63
22.00	0.27
22.50	-0.09
23.00	-0.46
23.50	-0.84

IOL @ Target LF = 1.726
22.37 A = 118.700

AMO
Tecnis 1 ZCB00

Barrett Universal II	
IOL(D)	REF(D)
22.00	0.72
22.50	0.37
23.00	0.02
23.50	-0.34
24.00	-0.71

IOL @ Target LF = 2.041
23.02 A = 119.300

Alcon
SN60WF IQ (India)

Barrett Universal II	
IOL(D)	REF(D)
21.50	0.85
22.00	0.49
22.50	0.14
23.00	-0.23
23.50	-0.60

IOL @ Target LF = 1.880
22.69 A = 118.990

Hoya
XY1

Barrett Universal II	
IOL(D)	REF(D)
22.00	0.65
22.50	0.29
23.00	-0.06
23.50	-0.43
24.00	-0.79

IOL @ Target LF = 1.988
22.91 A = 119.200

Alcon
SA60AT

Barrett Universal II	
IOL(D)	REF(D)
22.00	0.64
22.50	0.28
23.00	-0.09
23.50	-0.46
24.00	-0.83

IOL @ Target LF = 1.780
22.88 A = 118.800

Alcon
SN60WF IQ (India)

Barrett Universal II	
IOL(D)	REF(D)
22.00	0.78
22.50	0.43
23.00	0.06
23.50	-0.30
24.00	-0.67

IOL @ Target LF = 1.880
23.09 A = 118.990

AMO
Sensar AR40E

Barrett Universal II	
IOL(D)	REF(D)
22.00	0.56
22.50	0.20
23.00	-0.17
23.50	-0.54
24.00	-0.92

IOL @ Target LF = 1.726
22.77 A = 118.700

Hoya
XY1

Barrett Universal II	
IOL(D)	REF(D)
22.50	0.58
23.00	0.23
23.50	-0.13
24.00	-0.50
24.50	-0.87

IOL @ Target LF = 1.988
23.32 A = 119.200

AMO
Tecnis 1 ZCB00

Barrett Universal II	
IOL(D)	REF(D)
22.50	0.66
23.00	0.31
23.50	-0.05
24.00	-0.41
24.50	-0.78

IOL @ Target LF = 2.041
23.43 A = 119.300



National Insurance
Company Limited

TPA ID No: HNS10146643424

Name: CHANDANA GUPTA

Address: 11, CENTRAL PARK, BEHIND KRISHNA
GLASS FACTORY, JADAVPUR E-Mail: sud

Age: 62 Yrs.

Blood Group:

Policy Number: 100600502210015846

Validity Period: 29/01/2023-28/01/2024

Policy Holder: SUDIPTA GUPTA

Relation with Policy Holder: Wife

HEALTH CARD



HERITAGE HEALTH



Emergency Contact no. of TPA : 033 2243 6026

Toll Free no. of TPA : 1800 345 3477

E-mail ID of TPA : heritage_health@bajoria.in

IRDAI License no. : 008

Website : www.heritagehealthtpa.com

CIN : U85195WB1998PTC088562

Terms & Condition :

1. This card is for identification purposes only
2. For cashless benefit, treatment has to be taken in network hospitals only. Preauthorisation is compulsory for cashless.
3. For planned hospitalization inform TPA at least 7 days before. For emergency cases, inform within 24 hours of admission.
4. For reimbursement claims, TPA has to be intimated within 7 days of hospitalization and prior to discharge.
5. All terms and conditions of the Insurance policy are applicable.

For grievance redressal, login to : niconline.co.in

पॉलिसी ३-नुसूची/ Policy Schedule- National Mediclaim Policy

पॉलिसी नंबर/ Policy Number:

100600502210015846

व्यवसाय स्रोत/Business Source: 100600

जारीकर्ता कार्यालय/Issuing Office

कार्यालय कोड /Office Code: 100600
कार्यालय ठिकाना /Office Address: KOLKATA
DIVISION VI First Floor, National Insurance Building, 8, India Exchange Place, Kolkata, - 700001.
राज्य कोड/State Code: 19, West Bengal
जीएसटीआइन/GSTIN: 19AACCN9967E1Z0
संपर्क संख्या/Contact Number: 33 22209299
मोबाइल नंबर/Mobile Number: 0

विक्रय चैनल विवरण/Sales Channel Details:

विक्रय चैनल कोड /Sales Channel Code:
9000000161

नाम /Name: Mr Arun Kumar Sahoo संपर्क

संख्या/Contact Number: 9433246793

सह दलाल कोड / Co Broker Code:

Product UIN No: NICLIP21558V062021

कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free Number: 1800 345 0330
ईमेल/email: customer.support@nic.co.in



ग्राहक का नाम /Customer Name: DR SUDIPTA GUPTA

पता/ Address: 11, CENTRAL PARK, BEHIND KRISHNA GLASS FACTORY, JADAVPUR, DIST. : KOLKATA, WEST BENGAL, शहर/ City: KOLKATA, ज़िला/District: KOLKATA, राज्य/State: WEST BENGAL, पिन/PIN: 700032.
सेवा/Ce I: 9433076660

ग्राहक आईडी /Customer ID:
9512841386

पैन /PAN: ADJPG8596M

आधार /AADHAR:
फोन /Phone: 9433076660

ई-मेल /E-Mail: sudiptagupta54@gmail.com

पॉलिसी प्रभावी होने का समय घंटे को Policy Effective from 00:00 hours, on 29/01/2023 की मध्य रात्रि तक प्रभावी/to midnight of 28/01/2024

प्रीमियम/ Premium	₹ 52,175.00	कवर नोट संख्या और तिथि / Cover Note Number and Date	लागू नहीं /NA
Less: Digital Discount	₹ 0.00		
Total Premium	₹ 52,175.00		
सीजीएसटी/CGST	₹ 4,696.00		
एसजीएसटी/प्रदीपीएसटी / SGST/UTGST	₹ 4,696.00	प्रस्ताव संख्या और तिथि/ Proposal Number and Date	8800220106162568 दिनांक/Dt. 29/11/2022
आईजीएसटी/IGST	₹ 0.00		
कम:जीएसटी/ एसजीएसटी / Less:GST_TDS	₹ 0.00		
वस्तू योग्य योग्य स्टाम्प ड्यूटी /Recoverable Stamp Duty	₹ 0.00	रसीद संख्या और तिथि/ Receipt Number and Date	100600812210020890 दिनांक/Dt. 17/01/2023
इन राशि /Total Amount	₹ 61,567.00	पिछली पॉलिसी संख्या और समाप्ति तिथि / Previous Policy Number and Expiry Date	101901502010008246 दिनांक/Dt. 28/01/2022 101901501910008782 दिनांक/Dt. 28/01/2021 101901501810009117 दिनांक/Dt. 28/01/2020 101901501710008883 दिनांक/Dt. 28/01/2019 101901501610005715 दिनांक/Dt. 28/01/2018 100600502110008915 दिनांक/Dt. 28/01/2023

(रुपय/Rupees Sixty One Thousand Five Hundred Sixty Seven केवल/Only.)

*सरकारी सहिती Government Subsidy: ₹ 0.00

Subsidy:

बीमित व्यक्ति का विवरण/ Details of Insured Persons

क्र.सं./S.No	बीमित व्यक्ति का नाम/ Name of the Insured Person	जन्म-तिथि/ आयु / Date of Birth Age	संबंध पेशा/ Relation- Occupation	लिंग/ Gender	बीमा राशि (₹.) सीबीराशि/ Sum Insured(') CB Amount(')	Home Care Treatment
1	SUDIPTA GUPTA	22/12/1954 68	Self-Aff - Occupation	Male	300000 150000	NA
2	CHANDANA GUPTA	06/10/1960 62	Wife-Housewife	Female	300000 150000	NA

वैकल्पिक कॉमोराइट विवरण /Optional Copayment details :-

सह भुगतान/co payment %:NA

नामांकित विवरण /Nominee Details

दिनांक को मुद्रित/Printed on 17/01/2023 आईडी नंबर/by ID: 73801

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड

National Insurance Company Limited

CIN U10200WB1906GOI001713 IRDA Regn. No. -58

पृष्ठ सं.Page no: 1

पंजीकृत एवं प्रधान कार्यालय: 3 मिडलटन स्ट्रीट कोलकाता 700 071

Registered & Head Office: 3 Middleton Street, Kolkata-700 071

Ph. : 033-2283 1705-06, email : website.administrator@nic.co.in

प्रमाण-पत्र /Certificate- National Mediclaim Policy

पोलिसी नंबर /Policy Number:

100600502210015846

व्यवसाय स्रोत /Business Source: 100600

विक्रय चैनल विवरण/ Sales Channel Details

विक्रय चैनल कोड/ Sales Channel Code:

9000000161

नाम/ Name: Mr Arun Kumar Sahoo

संपर्क संख्या/Contact Number: 9433246793

सह दलाल कोड / Co Broker Code:

Product UIN No: NICLIP21558V062021

जारीकर्ता कार्यालय/Issuing Office

कार्यालय कोड /Office Code: 100600

कार्यालय पता /Office Address: KOLKATA
DIVISION VI First Floor, National Insurance
Building, 8, India Exchange Place, Kolkata, -
700001.

राज्य कोड/State Code: 19, West Bengal

जीएसटीआई/ GSTIN: 19AACN9967E1Z0

संपर्क संख्या/Contact Number: 33 22209299

मोबाइल नंबर/Mobile Number: 0

कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free

Number: 1800 345 0330

ईमेल/email: customer.support@nic.co.in

नामांकित व्यक्ति का नाम/ Name of the Nominee

SAYAN GUPTA

बीमित व्यक्ति के साथ संबंध/ Relationship with Insured

Son

Frequency of Premium Payment: Annual

एफ1/

टीपीए का विवरण/ TPA Details: HERITAGE HEALTH TPA PVT LTD - KOLKATA CRO I, Fifth Floor, Nicco House, 2, Hare Street, Kolkata - 700001 Contact No : 33 - 22486430 Email : hhsplaccounts@bajoria.in.

जिसकी गवाही में दिन/ माह/वर्ष को उपरोक्त उल्लिखित कार्यालय परे पर अधोहस्ताक्षरी को विधिवत् अधिकृत किया जा रहा है उसके हाथ निर्धारित किए जाएं। यह अनुसूची, संलग्न पोलिसी, खण्ड, पृष्ठांकन और पोलिसी शब्दों, जो कंपनी वेबसाइट <https://nationalinsurance.nic.co.in> पर उपलब्ध हैं, को एक अनुबंध के रूप में एक साथ पढ़ा जाए तथा कोई भी शब्द या अभिव्यक्ति जिसके लिए यह विशेष अर्थ पोलिसी या अनुसूची के किसी भी हिस्से में संलग्न किया गया हो, एक ही अर्थ वहन करेगा जाहे जहाँ भी उल्लिखित हो। यह आश्वासन दिया जाता है कि प्रीमियम चेक की अस्वीकृति के मामले में, यह दस्तावेज स्वतः आरंभ से ही निरस्त मानी जाएगी। */IN WITNESS WHEREOF, the undersigned being duly authorized hereunto set his/ her hand at the office address mentioned above, this 17/January/2023. This schedule, the attached policy, the clauses, the endorsements and policy wordings as available in the website <https://nationalinsurance.nic.co.in> shall be read together as one contract and any word or expression to which the specific meaning has been attached in any part of this policy or of the schedule shall bear the same meaning wherever it may appear. It is warranted that IN CASE OF DISHONOUR OF THE PREMIUM CHEQUE, THIS DOCUMENT STANDS AUTOMATICALLY CANCELLED 'AB-INITIO'*

इंश्योरेन्स ऑफिसलिमिटेड ऑफिसमैन का विवरण/Ombudsman Details: Office of the Insurance Ombudsman, Hindustan Bldg. Annex, 7th Floor, 4, C.R. Avenue, Kolkata - 700072.

Tel.: 033 - 22124339 / 22124340

Email: bim.alokp.al.kolkata@cioins.co.in

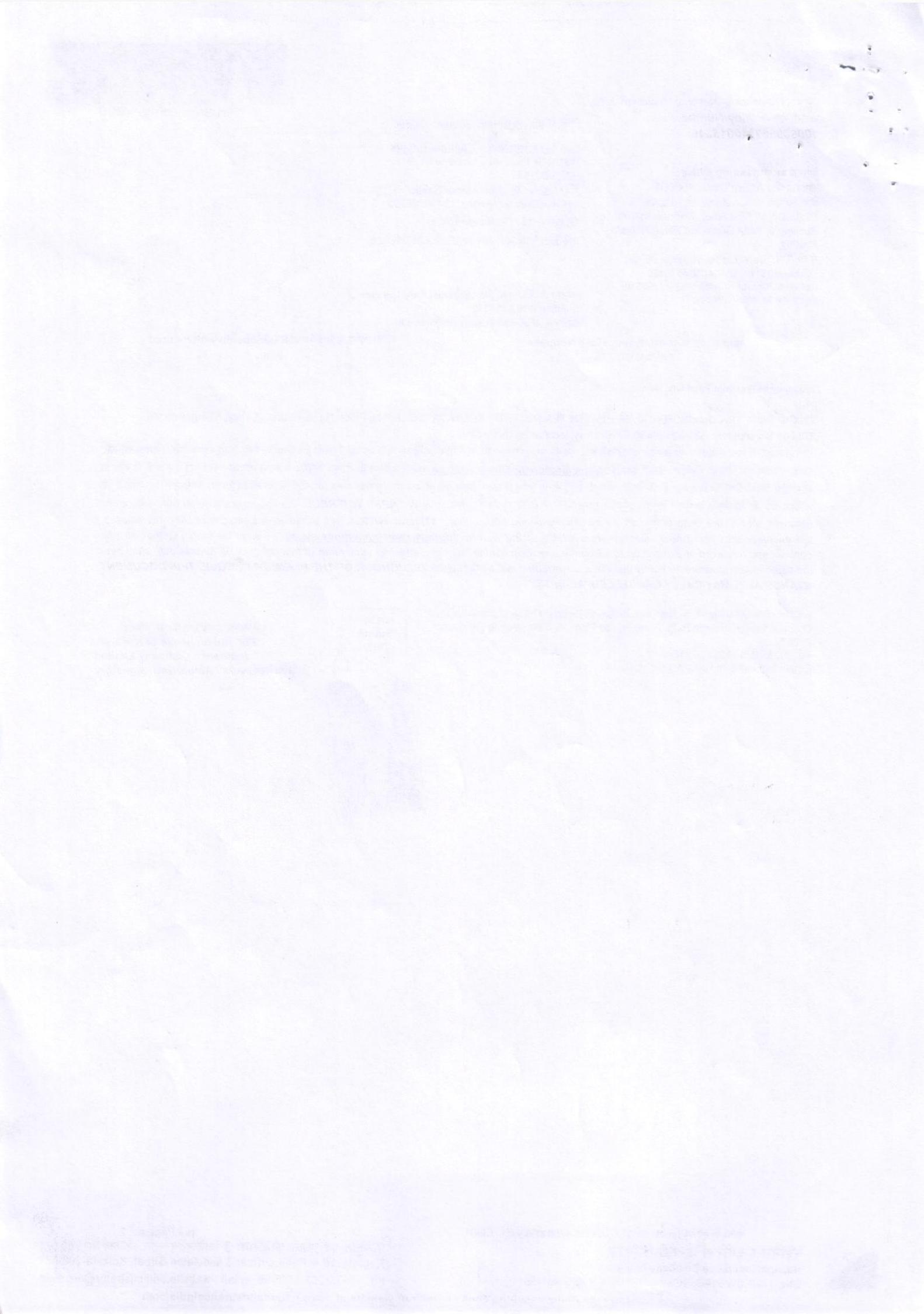
स्टॉप ड्यूटी
Stamp
Duty:
(₹ 0.25)



कृते नेशनल इन्श्योरेन्स कंपनी लिमिटेड/

For and on behalf of National
Insurance Company Limited

अधिकृत हस्तात्करकता/ Authorized Signatory



*** Risk involved in eye surgery**

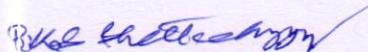
Like all Operations Eye Surgery also has some risks but relatively less than General surgeries.

About 98% of patients have good visual recovery. Some cases may not show good visual recovery like
a.Cataract due to injury.

b.Diabetic and or hypertensive patients.

c.Patients with extremely high myopia.

d.Patients suffering from diseases like Glaucoma, night blindness or age related retinal/eye diseases etc.



Name of Consultant

Dr. Bikas Bhattacharya

MBBS, MS, D.O.

Visiting Eye and Laser Surgeon

Regn No 41712

Apollo Medical Centre

(Formerly Apollo Gleneagles Medical Centre), 48/1F, Leela Roy Sarani (Gariahat), Kolkata - 700 019

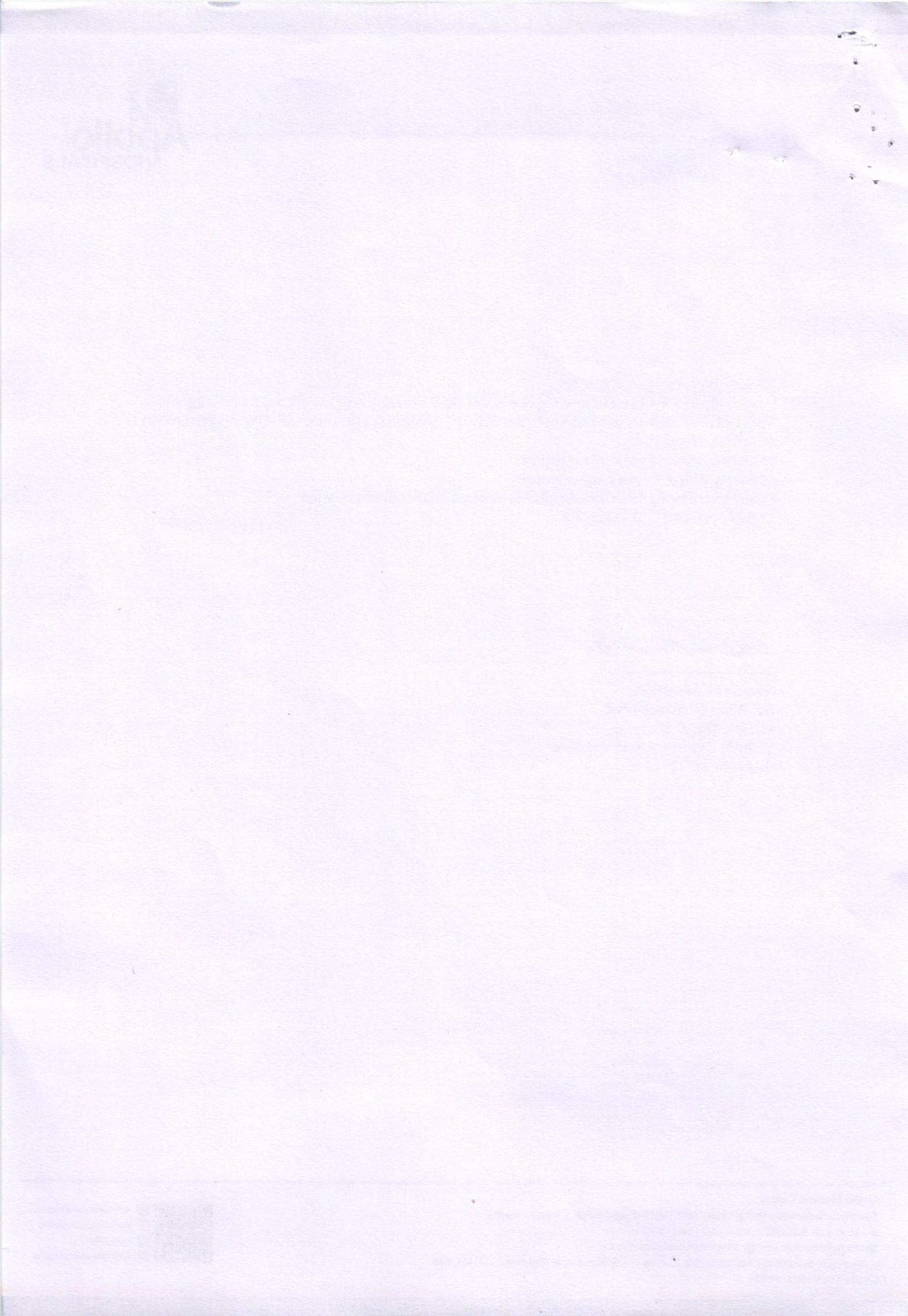
+91-33-2461 8028 / 8079 / 8451 / 8547 / 9482 / 8483

info@apollohospitals.com www.kolkata.apollohospitals.com

(A Unit of Apollo Multispeciality Hospitals Limited) 58, Canal Circular Road, Kolkata, West Bengal - 700 054, India.

CIN:U33112WB1988PLC045223

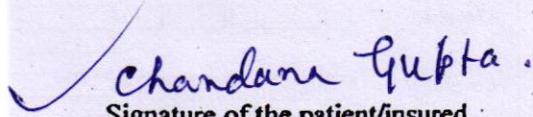




Annexure-C

Undertaking by the insured to the hospital in case higher room category is opted

I am aware that the rate approved by the TPA through Cashless authorisation letter i.e. Rs. 26,000/- is the amount sanctioned under my policy as per PPN package rate during the hospitalisation period. I understand that any payment over & above charged by the hospital will be borne by me and will not be reimbursed by the Insurer/TPA.

Chandan Gupta

Signature of the patient/insured

(Name of the Insured)

Date: 25.05.2023

Card no- HHS1.0146643424

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

DETAILS OF HOSPITAL

a) Name of the hospital: **APOLLO MEDICAL CENTRE**
 a) Hospital ID: c) Type of Hospital: Network: Non Network: (if non network fill section E)
 c) Name of the treating doctor: **S BIKAS BHATTACHARJEE**
 e) Qualification: f) Registration No. with State Code: **U1712** g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: **CHANDANA DOPTA** b) IP Registration Number: c) Gender: Male Female d) Age: Years **63** Months e) Date of birth: **DD MM YY**
 f) Date of Admission: **31 05 23** g) Time: **HH MM** h) Date of Discharge: **31 05 23** i) Time: **HH MM**
 j) Type of Admission: Emergency Planned Day Care Maternity k) If Maternity l) Date of Delivery: **DD MM YY** ii) Gravida Status:
 l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description
I. Primary Diagnosis	<input type="text"/>	<input type="text"/>
ii. Additional Diagnosis:	<input type="text"/>	<input type="text"/>
iii. Co-morbidities:	<input type="text"/>	<input type="text"/>
iv. Co-morbidities:	<input type="text"/>	<input type="text"/>
b)	ICD 10 PCS	Description
i. Procedure 1:	<input type="text"/>	<input type="text"/>
ii. Procedure 2:	<input type="text"/>	<input type="text"/>
iii. Procedure 3:	<input type="text"/>	<input type="text"/>
iv. Details of Procedure:	<input type="text"/>	

c) Pre-authorization obtained: Yes No d) Pre-authorization Number:
 e) If authorization by network hospital not obtained, give reason:
 f) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance abuse / alcohol consumption
 ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police Yes No
 v. FIR No. vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- | | |
|---|--|
| <input type="checkbox"/> Claim Form duly signed
<input type="checkbox"/> Original Pre-authorization request
<input type="checkbox"/> Copy of the Pre-authorization approval letter
<input type="checkbox"/> Copy of Photo ID Card of patient Verified by hospital
<input type="checkbox"/> Hospital Discharge summary
<input type="checkbox"/> Operation Theatre Notes
<input type="checkbox"/> Hospital main bill
<input type="checkbox"/> Hospital break-up bill | <input type="checkbox"/> Investigation reports
<input type="checkbox"/> CT/MR/USG/HPE investigation reports
<input type="checkbox"/> Doctor's reference slip for investigation
<input type="checkbox"/> ECG
<input type="checkbox"/> Pharmacy bills
<input type="checkbox"/> MLC reports & Police FIR
<input type="checkbox"/> Original death summary from hospital where applicable
<input type="checkbox"/> Any other, please specify: <input type="text"/> |
|---|--|

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital **48/1 LEELA ROY SARANI**
 City: **KOLKATA** State: **WEST BENGAL**
 Pin Code: **700019** b) Phone No. **24618451** c) Registration No. with State Code: **U331248**
 d) Hospital PAN: **AAECAT407E** e) Number of inpatient beds **10** f) Facilities available in the hospital
 i. OT Yes No ii. ICU Yes No
 iii. Others:

DECLARATION BY THE HOSPITAL

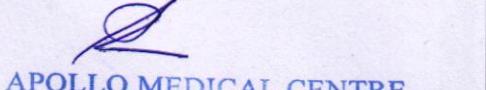
(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: **31 05 23**

Place: **KOLKATA**

Signature and Seal of the Hospital Authority:



APOLLO MEDICAL CENTRE

48/1F, LEELA ROY SARANI, KOLKATA - 700019

CE LICENCE NO- 34235670

VALID UPTO- 29-12-2025

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F