252100

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

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL

a. Name of TPA / Insurance company: VIDAL HEALTH INSURANCE TPA PRIVATE LTD.

b. Toll free phone number:

c. Toll free fax:

d. Name of Hospital:

i. Address

ii. Rohini id

iii. e-mail id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : MEGHNA. S. WARRIER.

B. Gender: ☐ Male ☑ Female ☐ Third Gender

C. Age: 16 / (Years) / (Month)

D. Date of Birth: 05/12/2003 (DD/MM/YYYY)

E. Contact number: 9900514208

F. Contact number of attending Relative: 9945685823.

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 Shirpal

B. Contact number:

C. Nature of Illness / Disease with presenting complaint: C/o cough & fever since 1 week

D. Relevant Critical Findings:

E. Duration of the present ailment: _____ Days

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

ii. Past history of present ailment, if any

F. Provisional diagnosis: Impl/Rt / left-sided Pneumonia

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 Medical management

i. Route of Drug Administration : IV

I. If surgical, name of surgery

i. ICD I0 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	9/01/2020 (DD/MM/YYYY)
B.	Time of admission	_____ (HH:MM)
C.	Is this an emergency / planned hospitalization event:	Emergency ☐ Planned ☐
D.	Mandatory Past History of any chronic illness	if yes (since __/____)(month/year)
	i. Diabetes	/
	ii. Heart disease	/
	iii. Hypertension	/
	iv. Hyperlipidemias	/
	v. Osteoarthritis	/
	vi. Asthma/COPD/Bronchitis	/
	vii. Cancer	/
	viii. Alcohol/Drug abuse	/
	iX. Any HIV/ or STD Related ailment	/
	X. Any other ailment, give details	
E.	Expected number of Days / stay in hospital	_____ Days
F.	Days in ICU	_____ Days
G.	Room Type	Twin bed
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	Approx- 50000/-

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 Shirday

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: MEGHNA . S . WARRIER .

b) Contact Number: 9900514208 email-Id (optional) SUNILWARRIOR@GMAIL.COM.

c) 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 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: _____

PPN NETWORK - DECLARATION BY PATIENT/PATIENT'S ATTENDANT

Name of the Hospital :COLUMBIA ASIA HOSPITAL Date :.....

Address :WHITEFIELD, BANGALORE

PATIENT NAME (BLOCK LETTERS) :.....MEGHNA S WARRIER..... AGE/SEX :.....16/FEMALE.....

IP No :.....25205..... UHID No :..... Mobile No of Patient :.....9900514208.....

Date of Admission :.....09/01/2020..... Time of Admission :.....

Date of Discharge :..... Time of Discharge :.....

Address of the Patient :.....

NAME OF THE ATTENDANT :..... Relationship with the Patient :.....

Mobile No. of Attendant :..... Address :.....

Declaration regarding Insurance Policy (Strike off the option which is not applicable)

(i) ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

(ii) ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

Policy No/TPA card No: ~~BLR~~-01-A1243-001-0304920-C.

Insurance Company: ~~VIDAL~~ HEALTH.

2) Whether patient opted for Eligible Room Category under Policy:
Yes / No

3) In case, policyholder wishes to avail better facility:

Name of the Additional Facility/ Provision/ Procedure/ Treatment .....
..... which costs Rs :.....
(In words: .....
.....
.....) only.

On my own option, I wish to avail above better 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 Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed PPN tariff. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed PPN tariff rates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better 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.

COLUMBIA ASIA HOSPITAL BANGALORE

Signature :.....
Name of the Patient/Patient's attendant:

Signature :.....
Name of the Hospital Representative & Hospital Seal :

THE ORIENTAL INSURANCE CO. LTD.

VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR

Card No : BLR-OI-A1243-001-0304920-A
SUNIL RAMACHANDRAN
Sex : M **Age :** 46 Year/s
Relationship : Self

ACCENTURE
Valid From : 17-Oct-2019
Emp No : 11090443

24x7 Helpline No.: 18604250258/08049166701/702/703

This card is non-transferable. It is used only for identification purposes and not as an authorisation to proceed with the treatment or as any guarantee for payment. Use of this card is governed by the policy terms & conditions. This card is valid at hospitals empanelled with Vidal Health Insurance TPA Private Limited. Cashless hospitalisation can be availed of but it is subject to preauthorisation approved by Vidal Health. In case preauthorisation is not approved, the policy holder is required to make payment to the hospital and submit the claims to Vidal Health for a possible reimbursement. For hospitalisation bills pertaining to non medical expenses, the policy holder is required to make payment to the hospital directly. This card is to be produced with Pan Card/Passport/Driver's License/Voter's ID card to prove identity of the claimant. This card is valid subject to continued renewal of the policy. Vidal Health Insurance TPA Private Limited is your authorised Third Party Administrator.

For an updated hospital list with local contact details please visit: **www.vidalhealthtpa.com**

VIDAL HEALTH

Bangaluru: 080-40125600, **Bhubaneswar:** 0674-2530392, **Chennai:** 044-42894444
Coimbatore: 0422-2491335, **Delhi:** 011-23715781, **Hyderabad:** 040-66061300/01
Kochi: 0484-2358683, **Kolkata:** 033-22884198, **Mumbai:** 022-29214700
Pune: 020-25530398, **Vizag:** 0891-6670197

If found please return to:
Vidal Health Insurance TPA Private Limited
Tower No. 2, First Floor, SJR I Park, EPIP Zone, Whitefield, Bangalore-560 066.
E-mail: help@vidalhealthtpa.com **Website:** www.vidalhealthtpa.com

THE ORIENTAL INSURANCE CO. LTD.

VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR

Card No : BLR-OI-A1243-001-0304920-B
RAKHI WARRIER
Sex : F **Age :** 41 Year/s
Relationship : Spouse

ACCENTURE
Valid From : 17-Oct-2019
Emp No : 11090443

24x7 Helpline No.: 18604250258/08049166701/702/703

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THE ORIENTAL INSURANCE CO. LTD.

VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR

Card No : BLR-OI-A1243-001-0304920-C
MEGHNA S WARRIER
Sex : F **Age :** 15 Year/s
Relationship : Child

ACCENTURE
Valid From : 17-Oct-2019
Emp No : 11090443

24x7 Helpline No.: 18604250258/08049166701/702/703

This card is non-transferable. It is used only for identification purposes and not as an authorisation to proceed with the treatment or as any guarantee for payment. Use of this card is governed by the policy terms & conditions. This card is valid at hospitals empanelled with Vidal Health Insurance TPA Private Limited. Cashless hospitalisation can be availed of but it is subject to preauthorisation approved by Vidal Health. In case preauthorisation is not approved, the policy holder is required to make payment to the hospital and submit the claims to Vidal Health for a possible reimbursement. For hospitalisation bills pertaining to non medical expenses, the policy holder is required to make payment to the hospital directly. This card is to be produced with Pan Card/Passport/Driver's License/Voter's ID card to prove identity of the claimant. This card is valid subject to continued renewal of the policy. Vidal Health Insurance TPA Private Limited is your authorised Third Party Administrator.

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E-mail: help@vidalhealthtpa.com **Website:** www.vidalhealthtpa.com

accenture

11090443

SUNIL R

भारत सरकार

भारतीय विशिष्ट पहचान प्राधिकरण
भारत सरकार
Unique Identification Authority of India
Government of India

आधार

E-Aadhaar Letter

ಪ್ರವೇಶ ಸಂಖ್ಯೆ / Enrolment No.: 1189/03145/02417

Date: 21/07/2013

Meghna S Warrier (ಮೇಘನಾ ಸ ವರರಿಎರ್)

D/O: Sunil R, ff 102 sai mithra Apartment, 7th main, Hopefarm Junction Maithri layout, Bangalore North, Whitefield, Bangalore

Karnataka, 560066

ನಿಮ್ಮ ಆಧಾರ್ ಸಂಖ್ಯೆ/ Your Aadhaar No.:

6304 7131 3674

ಆಧಾರ್ - ಆಧಾರ್ – ಶ್ರೀಸಾಮಾನ್ಯನ ಅಧಿಕಾರ

1947
1800 300 1947

help@uidai.gov.in

www.uidai.gov.in

ಮಾಹಿತಿ

- ಆಧಾರ್ ಆಧಾರ್ ಎನ್ನುವುದು ಗುರುತಿನ ಪುರಾವೆಯಾಗಿದೆ, ನಾಗರಿಕತೆಗಾಗಿ ಅಲ್ಲ.
- ಗುರುತಿನ ಪುರಾವೆಯನ್ನು ಆನ್‌ಲೈನ್ ಅಥೆಂಟಿಫಿಕೇಶನ್ ಮುಲಕ ಪಡೆಯಬಹುದಾಗಿದೆ
- ಇಲೆಕ್ಟ್ರಾನಿಕ್ ಪ್ರಕ್ರಿಯೆ ಮುಲಕ ತಯಾರಿಸಲಾಗಿರುವ ಪತ್ರ ಇದಾಗಿದೆ.

ಗಮನಿಸಿ:ಮಗುವಿಗೆ 15 ವರ್ಷ ಪ್ರಾಯ ತುಂಬಿದಾಗ ಬಯೋಮೆಟ್ರಿಕ್ ವೈಶಿಷ್ಟತೆಗಳನ್ನು ದಾಖಲಿಸಿಕೊಳ್ಳಿ.

INFORMATION

- Aadhaar is proof of identity, not of citizenship.
- To establish identity, authenticate online.
- This is electronically generated letter.

Note: Children on attaining 15 year of age need to update biometric information.

Validity unknown

Digitally signed by Kharakwal Amitabh
Date: 21/07/2013

- ಆಧಾರ್ ದೇಶದಾದ್ಯಂತ ಮಾನ್ಯತೆಯನ್ನು ಪಡೆದಿದೆ.
- ಆಧಾರ್ ಆಧಾರ್‌ಗಾಗಿ ಒಂದು ಬಾರಿ ನಿಮ್ಮ ಹೆಸರನ್ನು ನೊಂದಾಯಿಸಿಕೊಳ್ಳುವುದು ಅತ್ಯಂತ ಅಗತ್ಯವಾಗಿರುತ್ತದೆ
- ದಯವಿಟ್ಟು ನಿಮ್ಮ ಇತ್ತೀಚಿನ ಮೊಬೈಲ್ ನಂಬರ್ ಮತ್ತು ಇ-ಮೇಲ್ ವಿಳಾಸವನ್ನು ನೊಂದಾಯಿಸಿ. ಇದರಿಂದಾಗಿ ನಿಮಗೆ ಅನೇಕ ಸೌಲಭ್ಯಗಳನ್ನು ಪಡೆಯುವುದಕ್ಕಾಗಿ ಅನುಕೂಲವಾಗುತ್ತದೆ.

- Aadhaar is valid throughout the country.
- You need to enrol only once for Aadhaar.
- Please update your mobile number and e-mail address. This will help you to avail various services in future.

भारत सरकार
GOVERNMENT OF INDIA

ಮೇಘನಾ ಸ ವರರಿಎರ್
Meghna S Warrier
ಜನನ ವರ್ಷ/YoB:2003
ಹೆಣ್ಣು Female

6304 7131 3674

ಆಧಾರ್ - ಆಧಾರ್ – ಶ್ರೀಸಾಮಾನ್ಯನ ಅಧಿಕಾರ

भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

ವಿಳಾಸ:
D/O: ಸುನೀಲ್ ಆರ್, ಫ್ 102 ಸಾಯಿ ಮಿತ್ರ ಅಪಾರ್ಟ್‌ಮೆಂಟ್‌ನ, 7ನೇ ಮೇನ್, ಹೊಪೇಫಾರ್ಮ್ ಜಂಕ್ಶನ್ ಮೈತ್ರಿ ಲೇಔಟ್, ಬೆಂಗಳೂರು ಉತ್ತರ, ವ್ಹಿಟೇಫೀಎಲದ, ಬೆಂಗಳೂರು ಕರ್ನಾಟಕ, 560066

Address:
D/O: Sunil R, ff 102 sai mithra Apartment, 7th main, Hopefarm Junction Maithri layout, Bangalore North, Whitefield, Bangalore
Karnataka, 560066

Aadhaar - Aam Aadmi ka Adhikar