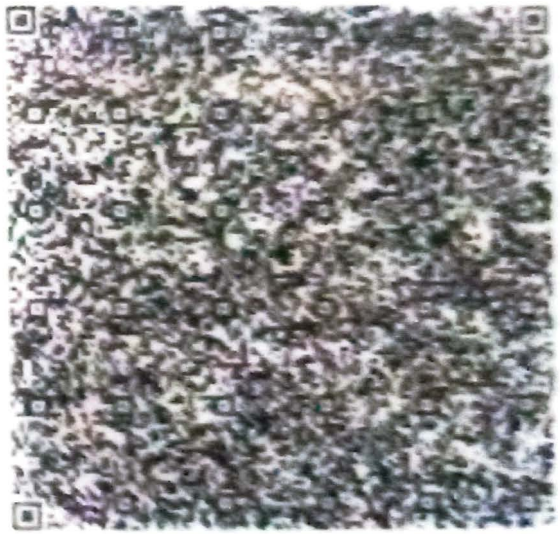
आयकर विभाग
INCOME TAX DEPARTMENT

भारत सरकार
GOVT. OF INDIA

स्थायी लेखा संख्या कार्ड
Permanent Account Number Card

EWVPB3881H



06122019

नाम / Name
BODAPATI ARUN TEJA

पिता का नाम / Father's Name
GANGARAJU BODAPATI

जन्म की तारीख /
Date of Birth
22/05/1998

B. Arun Teja

हस्ताक्षर / Signature

इस कार्ड के खोने/पाने पर कृपया सूचित करें/लौटाएं:

आयकर पैन सेवा इकाई, एन एस डी एल
चौथी 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
4th 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

8978855646

SRI SWATHI HOSPITAL

46-12-12/2, Sagar Hospital Road, Danaviapeta, RAJAMAHENDRAVARAM - 533103, E.G.District, (A.P)

(1)

Pt. Name : B. Arun Teja I.D. No.: 3147

Age / Sex : 25/M Address : peddavam

Dr. G. Sai Krishna, MD
General Medicine
Regd.No.: 86364

Date : 03-09-2023

Discharge summary

patient name B. Arun Teja, aged 25years, male admitted in Sri Swathi hospitals, rajamahendravaram on 29-08-2023 with viral fever with Thrombocytopenia; patient was treated Conservatively with medical management, patient general Condition and platelet counts reaches Normal limits; patient was clinically & mentally stable. patient discharged on 03-09-2023. further, patient was adviced medication, bed rest & medical checkup.

B. Arun Teja
6/10/2023

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(2)

SRI SWATHI HOSPITAL

Opp.Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM
Ph no: 8978855646 -533 103, E.G.DST(AP)

Patient name : B.Arun Teja Age/Sex:25/M

Address : Peddevam I.D.no.3147/2023

Date of Admission : 29/08/2023 Name of Doctor : G.Sai Krishna,MD.General

Date of Discharge : 03/09/2023

Sl.no	Type of Charges	Amount per day	Total Amount
1.	Room Charges	2,000 x 6 days	= 12,000/-
2.	Doctor Consultation	500 x 6 days	= 3,000/-
3.	Nursing Charges	500 x 6 days	= 3,000/-
4.	Treatment Charges	500 x 6 days	= 3,000/-
		Total	= **21,000/-**
		PHARMACY	= **18,525/-**
		INVESTIGATION	= **4,700/-**
		Total Bill	= **44,225/-**

Date : 08-09-2023

Place : Rajahmundry

B.Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(3)

SRI SWATHI MEDICALS

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 29.08.2023

S.no	.Medicine	quantity	Amount
1	NS-500ml	2	79/-
2	RL-500ml	1	63/-
3	NS-100ml	2	44/-
4	INJ.PANTOP-40	2	110/-
5	INJ.SULBACT	2	1620/-
6	INJ.LARINAT	2	874/-
7	10CC	6	102/-
8	2CC	3	15/-
9	INJ.MVI	1	30/-
10	IV.CANNULA	1	195/-
11	IV.SET	1	180/-
12	EASY FIX	1	70/-
13	TAB.DOLO-650	10	20/-
14	TAB.C-NAP	10	120/-
15	TAB.DOXYCYCLINE	10	135/-
16	DNS	1	43/-

TOTAL: 3,700/-

B. Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMP/96364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(4)

SRI SWATHI MEDICALS

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 30.08.2023

S.no	.Medicine	quantity	Amount
1	NS-500ml	2	79/-
2	RL-500ml	1	63/-
3	NS-100ml	2	44/-
4	INJ.PANTOP-40	2	110/-
5	INJ.SULBACT	2	1620/-
6	INJ.LARINAT	2	874/-
7	10CC	6	102/-
8	INJ.MVI	1	30/-
9	DNS	1	43/-
10	INJ.ONDAM	1	74/-

TOTAL: 3,039/-

B. Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(3)

SRI SWATHI MEDICALS

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 31.08.2023

S.no	.Medicine	quantity	Amount
1	NS-500ml	2	79/-
2	RL-500ml	1	63/-
3	NS-100ml	2	44/-
4	INJ.PANTOP-40	2	110/-
5	INJ.SULBACT	2	1620/-
6	INJ.LARINAT	2	874/-
7	10CC	6	102/-
8	INJ.MVI	1	30/-
9	DNS	1	43/-

TOTAL: 2,965/-

B. Arun Teja
6/10/2023

Signature of
Hospital Authority
Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(6)

SRI SWATHI MEDICALS

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 01.09.2023

S.no	.Medicine	quantity	Amount
1	NS-500ml	2	79/-
2	RL-500ml	1	63/-
3	NS-100ml	2	44/-
4	INJ.PANTOP-40	2	110/-
5	INJ.SULBACT	2	1620/-
6	INJ.LARINAT	2	874/-
7	10CC	6	102/-
8	INJ.MVI	1	30/-
9	DNS	1	43/-
10	IV.CANNULA	1	195/-

TOTAL: 3,160/-

B. Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAI KRISHNA
MBBS, M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(7)

SRI SWATHI MEDICALS

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 02.09.2023

S.no	.Medicine	quantity	Amount
1	NS-500ml	2	79/-
2	RL-500ml	1	63/-
3	NS-100ml	2	44/-
4	INJ.PANTOP-40	2	110/-
5	INJ.SULBACT	2	1620/-
6	INJ.LARINAT	2	874/-
7	10CC	6	102/-
8	INJ.MVI	1	30/-
9	DNS	1	43/-

TOTAL: 2,965/-

B.Arun Teja

6/10/2023

Signature of Hospital Authority

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(9)

SRI SWATHI MEDICALS

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 03.09.2023

S.no	.Medicine	quantity	Amount
1	INJ.SULBACT	1	820/-
2	INJ.PANTOP-40	1	50/-
3	INJ.LARINAT	1	437/-
4	NS-100ml	1	22/-
5	10CC	3	51/-

TOTAL: 1,380/-

B. Arun Teja
6/10/2023

Signature of Hospital Authority

Dr. G. SAI KRISHNA
MBBS, MD (General Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(9)

SRI SWATHI MEDICALS

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 03.09.2023

S.no	.Medicine	quantity	Amount
1	TAB.CEFOPOD-CV	10	450/-
2	TAB.P-BIT-DSR	10	196/-
3	TAB.LIMCEE	10	200/-
4	SYR.CEFEIN	1	120/-
5	PROTEINEX POWDER	1	350/-

TOTAL: 1,316/-

B. Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(10)

SRI SWATHI DIAGNOSTIC LABORATORY

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 29.08.2023

S.no	Type of Charges	Amount
1	HAEMATOLOGY	300/-
2	RBS	100/-
3	RFT	200/-
4	LIVER FUNCTION TEST	400/-
5	SEROLOGY	1200/-
6	BL.GROUP	100/-

TOTAL: 2,300/-

B.Arun Teja
6/10/2023

Signature of Hospital Authority

Dr. G. SAI KRISHNA
MBBS, M.D. (Gen. Medicine)
Reg. No. APMC/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(11)

SRI SWATHI DIAGNOSTIC LABORATORY

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103.

Name:	B.Arun Teja	Age/Sex:	25/Male
Ref.Dr:	G.Sai Krishna,MD.General	Date:	30.08.2023

S.no	Type of Charges	Amount
1	HAEMATOLOGY	300/-

TOTAL: 300/-

B. Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAIKRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(12)

SRI SWATHI DIAGNOSTIC LABORATORY

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 31.08.2023

S.no	Type of Charges	Amount
1	HAEMATOLOGY	300/-

TOTAL: 300/-

B. Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/96364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(13)

SRI SWATHI DIAGNOSTIC LABORATORY

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 01.09.2023

S.no	Type of Charges	Amount
1	HAEMATOLOGY	300/-

TOTAL: 300/-

B. Arun Teja
6/10/2023

Signature of
Hospital Authority
Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(14)

SRI SWATHI DIAGNOSTIC LABORATORY

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 02.09.2023

S.no	Type of Charges	Amount
1	HAEMATOLOGY	300/-

TOTAL: 300/-

B.Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMP/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(15)

SRI SWATHI DIAGNOSTIC LABORATORY

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name: B.Arun Teja Age/Sex: 25/Male

Ref.Dr: G.Sai Krishna,MD.General Date: 03.09.2023

S.no	Type of Charges	Amount
1	HAEMATOLOGY	300/-
2	RBS	100/-
3	RFT	200/-
4	LIVER FUNCTION TEST	400/-
5	CRP	200/-

TOTAL: 1,200/-

B.Arun Teja
6/10/2023

Signature of
Hospital Authority

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

(16)

Cell:8978855646

SRI SWATHI DIAGNOSTIC LABORATORY

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name : B.Arun Teja .Age : 25yrs Date 29.08.2023

Ref. Dr : G.Sai Krishna,MD.General Sex : Male Specimen: Blood

HAEMATOLOGY

Test	Result	Units	Normal Range
WBC	2,400	Cell / cumm	5,000 - 10,000
Neutrophils	52	%	46 – 78
Lymphocytes	37	%	4.0 – 40
Eosinophils	10	%	5 – 16
Monocytes	01	%	0 – 2
RBC	5.67	Millions	3.7 – 5.5
Hb%	15.2	gm/dl	10.0 – 16.0
HCT (PCV)	45.2	%	32 – 50
MCV	79.7	Fl	82.5 – 98.0
MCH	26.7	Fl	26.1 – 32.8
MCHC	33.6	Pg	30.7 – 35.9
PLATELETS	62,000	Cell / Lakhs	1,40,000 – 4,50,000

Blood Sugar R	101	mg/dl	70-140
RFT			
Blood Urea	24	mg/dl	15 – 40
S. Creatinine	0.81	mg/dl	0.4 – 1.4
Liver Function Test			
S. Bilirubin T	0.78	mg/dl	0.2-1.0
S. Bilirubin D	0.31	mg/dl	0.1-0.4
S. Bilirubin ID	0.47	mg/dl	0.2-0.7
S G O T	25	U/ml	8-40
S G P T	28	U/ml	5-35
S.Alk Phosphatase	74	U/L	25-140

SEROLOGY			
HB's, Ag	Negative		
HIV 1 & 2 Antibodies	Negative		
HCV	Negative		
CRP	**10.5**	mg/l	Up to 6.0

Bl.Group& Rh Type	" O " Positive

B. Arun Teja
6/10/2023

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/PNR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.

Signature

17

Cell:8978855646

SRI SWATHI DIAGNOSTIC LABORATORY

 # 46-12-25, Opposite to Sagar Nest Hospital,,Danavaipeta, RAJAMAHENDRAVARAM-533 103,

Name : B.Arun Teja .Age : 25yrs Date 02.09.2023

Ref. Dr : G.Sai Krishna,MD.General Sex : Male Specimen: Blood

HAEMATOLOGY

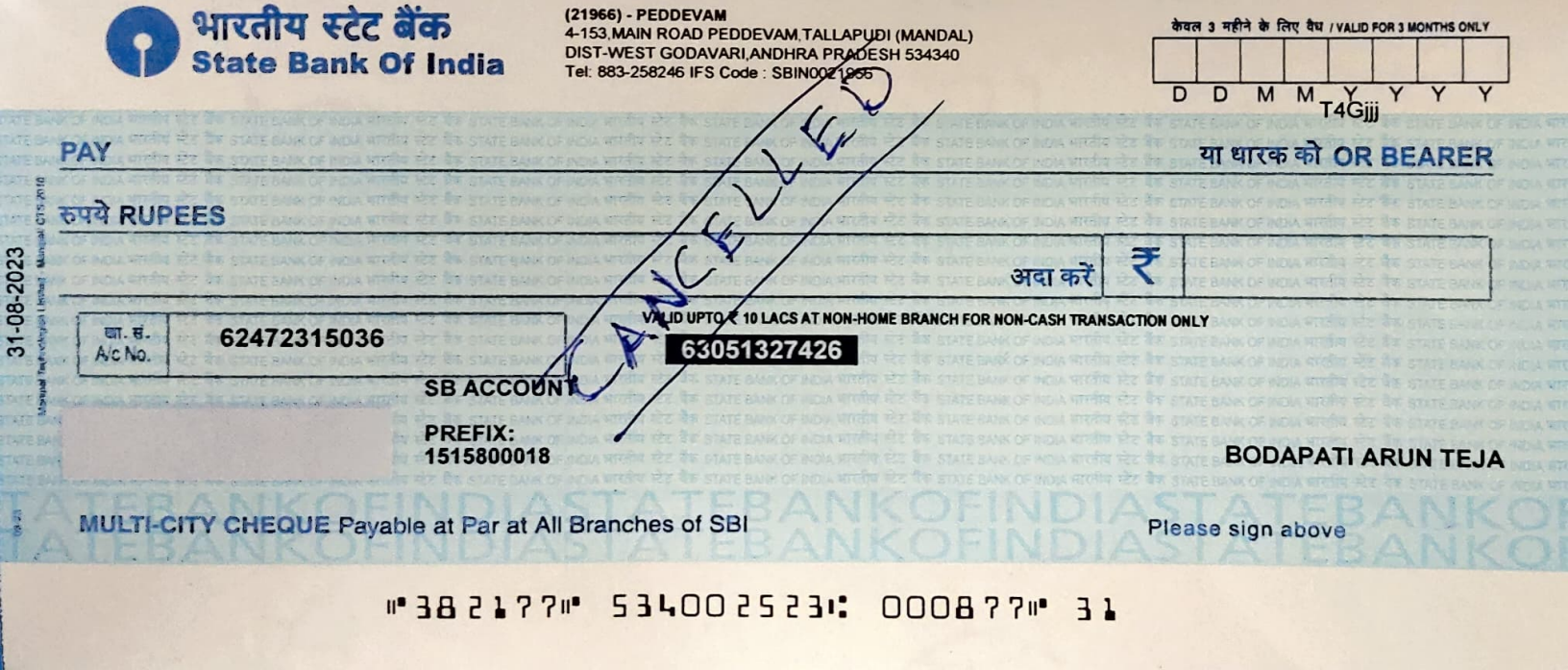
Test	Result	Units	Normal Range
WBC	6,500	Cell / cumm	5,000 - 10,000
Neutrophils	55	%	46 – 78
Lymphocytes	37	%	4.0 – 40
Eosinophils	07	%	5 – 16
Monocytes	01	%	0 – 2
RBC	5.33	Millions	3.7 – 5.5
Hb%	14.1	gm/dl	10.0 – 16.0
HCT (PCV)	43.1	%	32 – 50
MCV	81.0	Fl	82.5 – 98.0
MCH	26.5	Fl	26.1 – 32.8
MCHC	32.7	Pg	30.7 – 35.9
PLATELETS	1,75,000	Cell / Lakhs	1,40,000 – 4,50,000

B. Arun Teja

6/10/2023

Signature

Dr. G. SAI KRISHNA
MBBS., M.D. (Gen. Medicine)
Regd. APMC/FMR/86364
SRI SWATHI HOSPITALS
Danavaipeta, RAJAMAHENDRAVARAM.



भारतीय स्टेट बैंक
State Bank Of India

(21966) - PEDDEVAM
4-153,MAIN ROAD PEDDEVAM,TALLAPUDI (MANDAL)
DIST-WEST GODAVARI,ANDHRA PRADESH 534340
Tel: 883-258246 IFS Code : SBIN0021955

केवल 3 महीने के लिए वैध / VALID FOR 3 MONTHS ONLY
D D M M Y Y Y Y

T4Gjjj

PAY

या धारक को OR BEARER

रुपये RUPEES

अदा करें ₹

31-08-2023

VALID UPTO ₹ 10 LACS AT NON-HOME BRANCH FOR NON-CASH TRANSACTION ONLY

खा. सं. A/c No. 62472315036

63051327426

CANCELLED

SB ACCOUNT

PREFIX:
1515800018

BODAPATI ARUN TEJA

MULTI-CITY CHEQUE Payable at Par at All Branches of SBI

Please sign above

⑈382177⑈ 534002523⑆ 000877⑈ 31

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED BY THE INSURED

Z0015428626

DETAILS OF PRIMARY INSURED:

Policy No.:	**97000034220400000061_SEZ**	Sl. No/ Certificate no.			
Company/ TPA ID No:	**COGNIZANT TECHNOLOGY SOLUTIONS**				
Name:	**BODAPATIARUN TEJA**	EmpID:	**889869**	MAID:	**5058650779**
Address:					
City:	**EAST GODAVARI**	State:	**ANDHRA PRADESH**		
Pin Code:	**533103**	Phone No:	**9908450556**		
Email ID:	**BODAPATIARUN.TEJA@COGNIZANT.COM**				

DETAILS OF INSURANCE HISTORY:

Currently covered by any other Mediclaim / Health Insurance:	☐ Yes ☐ No	Date of commencement of first Insurance without break:	
If yes, company name:	**COGNIZANT TECHNOLOGY SOLUTIONS**	Policy No.:	**97000034220400000061_SEZ**
Sum insured (Rs.):		Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No	Date:
Diagnosis:		Previously covered by any other Mediclaim /Health insurance:	☐ Yes ☐ No

DETAILS OF INSURED PERSON HOSPITALIZED:

Name:	**ARUN TEJA BODAPATI**	Gender:	☑ Male ☐ Female
Age years:	**25**	Date of Birth:	
Relationship to Primary insured:	☑ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **FATHER** ☐ **MOTHER** ☐ **OTHER(PLEASE SPECIFY)**		
Occupation:	☐ **SERVICE** ☐ **SELF EMPLOYED** ☐ **HOME MAKER** ☐ **STUDENT** ☐ **RETIRED** ☐ **OTHER(PLEASE SPECIFY)**		
Address(if diffrent from above):			
City:	**EAST GODAVARI**	State:	**ANDHRA PRADESH**
Pin Code:	**533103**	Phone No:	**9908450556**
Email ID:	**BODAPATIARUN.TEJA@COGNIZANT.COM**		

DETAILS OF HOSPITALIZATION:

Name of Hospital where amited:	**SRI SWATHI HOSPITAL,DANAVAIPETA RAJAMAHENDRAVARAM,RAJAHMUNDRY,ANDHRA PRADESH**				
Room Category occupied:	☐ **DAY CARE** ☐ **SINGLE OCCUPANCY** ☐ **TWIN SHARING** ☐ **3 OR MORE BEDS PER ROOM**				
Hospitalization due to:	☐ **INJURY** ☐ **ILLNESS** ☐ **MATERNITY**	Date of injury / Date Disease first detected /Date of Delivery:	**29-AUG-2023**		
Date of Admission:	**29-AUG-2023**	Time:		Date of Discharge: **03-SEP-2023**	Time:
If injury give cause:	☐ **SELF INFLICTED** ☐ **ROAD TRAFFIC ACCIDENT** ☐ **SUBSTANCE ABUSE / ALCOHOL CONSUMPTION**	If Medico legal:	☐ **YES** ☐ **NO**		
Reported to Police:	☐ **YES** ☐ **NO**	MLC Report & Police FIR attached:	☐ **YES** ☐ **NO**	System of Medicine:	

DETAILS OF CLAIM:

Pre -hospitalization expenses	**INR**	Hospitalization expenses	**INR 44225**
Post-hospitalization expenses	**INR**	Health-Check up cost:	**INR**
Ambulance Charges:	**INR**	Others (code):	**INR**
Pre -hospitalization period:		Post -hospitalization period:	

Total: **INR 44225**

b) Claim for Domiciliary Hospitalization: ☐ **YES** ☐ **NO (IF YES, PROVIDE DETAILS IN ANNEXURE)**

c) Details of Lump sum / cash benefit claimed:

Hospital Daily cash:	**INR**	Surgical Cash:	**INR**
Critical Illness benefit:	**INR**	Convalescence:	**INR**

Total: **INR 44225**

Claim Documents Submitted - Check List:

☐ Claim form duly signed ☐ Copy of the claim intimation, if any ☐ Hospital Main Bill ☐ Hospital Break-up Bill ☐ Hospital Bill Payment Receipt

☐ Hospital Discharge Summary ☐ Pharmacy Bill ☐ Operation Theater Notes ☐ ECG

☐ Doctor?s request for investigation ☐ Investigation Reports (Including CT/ MRI / USG / HPE) ☐ Doctor?s Prescriptions ☐ Others

DETAILS OF BILLS ENCLOSED:

Sl No.	Bill No.	Date	Amount (Rs)	Remarks

DETAILS OF PRIMARY INSURED?S BANK ACCOUNT:

PAN:		Account Number:	**62472315036**
Bank Name:	**STATE BANK OF INDIA**	Branch:	**5BUSSTANDCENTREMAINROADPEDDEVAM**
Cheque / DD Payable details:		IFSC Code:	**SBIN0021966**

DECLARATION BY THE INSURED: I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement shall be forfeited, I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: Place:

Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
c) Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
c) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the Insurance Company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediclaim / Health Tick Yes or No Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
f) Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
1) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
b) Room category occupied	indicate the room category occupied	Tick the right option
c) Hospitalization due to	indicate reason of hospitalization	Tick the right option
d) Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh-mm- format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) If injury give cause	indicate cause of injury	Tick the right option
If Medico legal	indicate whether injury is medico legal	Tick Yes or No
Reported to Police	indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
i) System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)

b) Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d) Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option

SECTION F - DETAILS OF BILLS ENCLOSED

Indicate which bills are enclosed with the amount in rupees

SECTION G - DETAILS OF PRIMARY INSURED?s BANK ACCOUNT

a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank account number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
e) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full

SECTION H - DECLARATION BY THE INSURED

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.

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

DETAILS OF HOSPITAL:

a) Name of the hospital: **SRI SWATHI HOSPITAL,DANAVAIPETA RAJAMAHENDRAVARAM,RAJAHMUNDRY,ANDHRA PRADESH**

b) Hospital ID: c) Type of Hospital: ☐ Network ☐ Non Network (if non network fill section E)

d) Name of the treating doctor: e) Qualification:

f) Registration No. with State Code: g) Phone No.:

DETAILS OF THE PATIENT ADMITTED:

a) Name of the Patient: **ARUN TEJA BODAPATI**

b) IP Registration Number: c) Gender: ☐ Male ☐ Female d) Date of birth:

e) Date of Admission: **29-AUG-2023** Time: f) Date of Discharge: **03-SEP-2023** Time:

g) Type of Admission: ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity h) If Maternity: 1) Date of Delivery: 2) Gravida Status:

i) Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased j) Total claimed amount:

DETAILS OF AILMENT DIAGNOSED (PRIMARY):

a)	**ICD 10 Codes**	**Description**
I. Primary Diagnosis		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		
b)	**ICD 10 Codes**	**Description**
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		
iv. Details of Procedure		

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:

☐ Claim form duly signed ☐ Original Pre-authorization request ☐ Copy of the Pre-authorization approval letter ☐ Copy of Photo ID Card of patient Verified by hospital ☐ Hospital Discharge summary
☐ Operation Theatre Notes ☐ Investigation reports ☐ Hospital main bill ☐ Hospital break-up bill
☐ CT/MR/USG/HPE investigation reports ☐ Doctor?s reference slip for investigation ☐ ECG ☐ Pharmacy bills
☐ MLC reports & Police FIR ☐ Original death summary from hospital where applicable ☐ Any other, please specify

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

a) Address of the Hospital	**DANAVAIPETA,533103**				
City:	**EAST GODAVARI**	State:	**ANDHRA PRADESH**		
Pin Code:	**533103**	Phone No:	**9908450556**	Registration No. with State Code:	
Hospital PAN:		Number of inpatient beds			
Facilities available in the hospital	i. OT	☐ **YES** ☐ **NO**	ii. ICU	☐ **YES** ☐ **NO**	

DECLARATION BY THE HOSPITAL:

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: Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i) Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii) Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
b) Gender	Indicate Gender of the patient	Tick Male or Female
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text

Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or Not
FIR No.	Enter first information report number	As issued by police authrities
If not reported to police, give reason	Enter reason for not reporting to police	Open text

SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST

Indicate which supporting documents are submitted

SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify

SECTION F - DECLARATION BY THE HOSPITAL

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp