

**Subject:** Cashless Request 110202075357 is Approved at 23:24 for Amt INR 81000. Please contact hospital TPA desk for copy of approval letter

**From :** cashlessrequest@icicilombard.com

**Received Date and Time:** 2025-03-29 10:10:26



**Authorization Letter to the Hospital for the Treatment and Guarantee of Payment**

**(Part-D)**

Date : 28-MAR-25

AL Approved Date :28-MAR-25

**AL Requested Date : 28-MAR-25**

Apollo Hospitals  
Rohini ID :8900080201354  
21, Greams Road, Off. Greams Lane  
Chennai,Tamil Nadu-600006  
Tel: Mob:

**AL Number:110202075357**

Dear Sir/Madam,

We hereby authorize and guarantee for payment of Rs 81000 (in words) Rupees EIGHTY-ONE THOUSAND only.

Authorization is valid for 15 days from the date of approval or proposed date of admission, whichever earlier (Provided date of admission remains same).

Admission/ Pre-authorization request note sent by you with the following information:

Name of the Patient	:PREMA S	
UHID Number	:IL18126618703	<b>Policy related Deductions :</b>
Requested Room Type	:Day care Less Than 5 Hrs	Co-Pay :0
Class of Accommodation	:Day Care	Deductible :0
Provisional Diagnosis	:Chronic kidney disease, unspecified	BSI Exhaustion :0
Policy Period	:01-JUL-2024 To 30-JUN-2025	Sub Limit :0
Date of Admission	:01-APR-2025	Proportionate as per Eligible Room :0
Policy Name	:LARSEN & TOUBRO LIMITED	Non-Medical Expenses* (Please refer Annexure for details) :0
Patient IP No	:AC01.00027	Others: :0
Age	:69	Remarks (deductions will be calculated at the time of final settlement)
Gender	:FEMALE	
Policy No	:4016/X/202046748/04/000	<b>Network related Deductions (Not to be collected from Insured)</b>
Proposer Name	:	Hospital Tariff Deductions :0
Relation with Proposer	:MOTHER	Discounts
Date of Discharge	:30-APR-25	(Shall be applied at the time of Final Authorization) :0
Estimated length of stay	:30	
Proposed line of treatment	:MEDICAL	
Total Bill Amount	:81000	<b>Amount to be paid by Insured :</b>
UIN	:	<b>0</b>
BSI	:758865	<b>at discharge</b>

Event	Date & Time	Final Sanctioned Amount	Status
Initial Approved	28-MAR-2025 11:23:02 PM	81000	APPROVED
Final Approved Amount		81000	APPROVED

**Hospital Agreed Tariff :**

**1. Package case**

Agreed Package Rate :NA

**2. Non-package Case**

Hospital Agreed Tariff Non Package Case-Rent/day						
Room Rent	ICU Rent	Nursing Charges	Consultant Visit Charges	super specialist charges	Surgeon fee/OT/ Anaestheist	Others (Specify)
0	0	Included in Room Rent	0	0		0

**Remarks:**

Approved for Hemodialysis on day care basis. Please furnish the detailed course of hospitalization along with the discharge summary and the break-up of the final bill before discharge of the patient. claim will process as per MOU & policy T & C

“For any cashless queries, write on [cashlessrequest@icicilombard.com](mailto:cashlessrequest@icicilombard.com)”

**Note: "Please submit PAN of your hospital and Aadhaar Number of the Authorized Signatory (with copy) for settlement of the Claim."**

**Important Note:** This authorization is valid for Admission within 15 days from the Date of Admission mentioned or expiry /cancellation of the Insurance policy whichever is earlier. This Authorization becomes null and void if the patient is discharged before the date of this letter issuance. Copayment Amount has to be collected from Insured. Claim Processing / Settlement will be as per agreed rates in MOU/Tariff. This is an electronically generated document and this requires no seal / stamp

"If you have an alternative health insurance policy / policies from other insurance companies, kindly file a claim for the balance amount with this claim settlement letter of ICICI Lombard GIC. Also, do reach us out for any further requirement or assistance."

**Address:** ICICI Lombard GIC, ICICI Lombard Health Care, 01st, 04th, 05th & 06th Floor, Varun Towers II, Opp Hyderabad Public School, Begumpet, Hyderabad - 500016, Telangana.

Email: [ihealthcare@icicilombard.com](mailto:ihealthcare@icicilombard.com)

IRDA Registration No. 115.

#### Terms and Conditions of Authorization:

1. Cashless Authorization letter issued on the basis of information provided in Pre- Authorization form. In case Misrepresentation/concealment of the facts, any material difference/ deviation/ discrepancy in information is observed in Discharge summary/ IPD records then cashless authorization shall stand null & void. At any point of claim processing Insurer or TPA reserves right to raise queries for any other document to ascertain admissibility of claim.
2. KYC (Know your customer) details of proposer/employee/Beneficiary are mandatory for claim pay out above Rs 1 lakh.
3. Network provider shall not collect any additional amount from the individual 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)
4. Network provider shall not make any recovery 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)
5. 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 or get the same refunded to the policyholder from the Network Provider and/or take necessary action, as provided under the MoU
6. Where a treatment/procedure is to be carried out by a doctor/surgeon of insured's choice (not empaneled with the hospital), Network Provider may give treatment after obtaining specific consent of policyholder
7. Differential Costs borne by policyholder may be reimbursed by insurers subject to the terms and conditions of the policy

#### MANDATORY DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Diagnostic Test Reports and Receipts supported by note from the attending Medical Practitioner / Surgeon Recommending such Diagnostic supported by note from the attending Medical Practitioner/ Surgeon recommending such diagnostic tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon giving patient's condition and advice on discharge
6. **Implant Invoice**

*Important Instructions to Hospitals : 1) If the hospital bill is estimated to be higher than the guarantee of payment, a request letter for additional amount needs to be sent to ILGIC 2) If no further guarantee is available, the hospital must collect the excess amount directly from the beneficiary at the time of admission/ prior to discharge from the hospital, as per hospital rules and regulations 3) Please collect the hospital bill summary with final bill with details of units of each service (authenticated by*

patients signature). 4) Please collect the discharge summary and reports of all investigations (original). 5) Please collect an undertaking from the insured / patient for submitting his/her documents to ILGIC Ltd in original. 6) Charges for the following miscellaneous services and related allied services must be collected directly from the patient.i) Registration / admission charges ii) Ambulance charges (unless authorized) iii) Attendant / visitor pass charges. iv) Special nursing charges not authorized by the attending doctor v) Service charges not forming a part of the bed charges in general ward, maintenance charges, surcharges vi)Charges for extra bed for attendant etc vii)Bed retaining charges viii)Charges for TV, Laundry etc ix) Telephone/Fax charges x) Food and Beverages for attendants and visitors. xi) Toiletries etc xii) Purchase of medicines not related to the treatment xiii) Stationery, Xerox or certifying charges.

**Following Details are mandatory for claim settlement**

Date of Discharge Final Bill Amount by Patient	Amount Paid		
		Signature of the Patient/Relative	Hospital Stamp & Signature

All payments to Hospitals are subject to deduction of tax at source as per prevailing rate unless lower/nil TDS certificate had been provided to the payer, under section 194J as per Circular No 8/2009. Dated 24-11-2009 from Income Tax Dept



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[Apollo Hospitals Enterprise Ltd.](#)

**Reason :** (deductions will be calculated at the time of final settlement) Network related Deductions (Not to be collected from Insured) Hospital Tariff Deductions :0 Discounts (Shall be applied at the time of Final Authorization) :0 Amount to be paid by Insured : 0 at discharge Event Date & Time Final Sanctioned Amount Status Initial Approved 28-MAR-2025 11:23:02 PM 81000 APPROVED Final Approved Amount 81000 APPROVED Hospital Agreed Tariff : 1. Package case Agreed Package Rate :NA 2. Non-package Case Hospital Agreed Tariff Non Package Case-Rent/day Room Rent ICU Rent Nursing Charges Consultant Visit Charges super specialist charges Surgeon fee/OT/ Anaestheist Others (Specify) 0 0 Included in Room Rent 0 0 0