

File Received Date: 29/12/2020



No. of Documents

IHEALTH CARE

Documents Received From: Hospital / Member / Internal

<u>DNF</u>	<u>NEFT</u>	<u>PHOTOS</u>	<u>EPD</u>	<u>AADHAR</u>

POD S.No:- 439	POD NO:- PR01123715	Inward Date : - -DEC-2020
Inward Date & No.	CL-00	4844883
Patient Name	Manushi Thakur	
Policy Name	Advance	
Policy Classification	Retail / <u>Corporate</u> / Mass	
Type of Document	Network Reimbursement / <u>Member Reimbursement</u>	
Type of Claim	<u>Main Claim</u> / Pre-Post / Addendum / OPD / QueryResponse	
FP Exe:-KIRAN K	Pg Count Exec	Inward Exec:

X RAY FILMS:

IMPLANT STICKER:

IMPLANT STICKER BOX:

ICICI Lombard Health Care - Inward Report

Interaction ID	0311260478
File Received Date	29-12-2020
POD Number	PRO11123715
Courier Name	PROFESSIONAL
No of Documents	1
Policy Number	4016/X/170267623/01/000
UHID	IL17900585000
Customer Email ID	SONUMEENAKSHISINGH@GMAIL.COM
Customer Mobile Number	7842147194
Claim Amount	55000
Type of Document	Member Reimbursement
EFT	Yes



Nallakunta Branch

1-9-1114 To 1117, Main Road, Vidyanagarnallankunta, Hyderabad - 500 044

RTGS / NEFT IFS Code : ICIC0000370

VALID FOR THREE MONTHS ONLY

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D D M M Y Y Y Y

Pay

Or Bearer

या धारक को

Rupees रुपये

अदा करें।

₹

A/c No.

खाता क्र.

037001525337

VISA CARD

SBKIT

CBS

PERSONAL BANKING : NEW SAVINGS ACCOUNT

000073X037001525337000373X037001525337000373X037001525337

Payable at par at all branches of ICICI Bank Limited in India

18-10-17



Heenakshi

Please sign above

⑈000373⑈ 500229019⑈ 525337⑈ 31

(Issuance of this form is not to be taken as an admission of liability)

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS. REFER TO PART C.

Do You Know

- ★ Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals & mandatory documents
- ★ To receive update on your claim status, provide your mobile no. & E-mail ID
- ★ You can track your claim status at: www.icicilombard.com → Claims & wellness → IL Health care → Claims corner → Track your claims

Part - A (To be filled by Insured)

TO BE FILLED IN CAPITAL LETTERS ONLY

1. Type of Claim : Main Hospitalisation Expenses ☒ Pre & Post Hospitalisation Expenses ☐ Cashless Obtained: Yes ☐ No ☒
2. Name of the Proposer*: NEENAKSHI THAKUR
- Relationship with the Proposer*: SELF (* Proposer is the person who has paid premium for the policy)
- Current Policy No.:
- Card No./UHID: IL17900585000

- | 3. For Group/ Corporate Policy | For Individual/ Retail Policy (*Mandatory) |
|---|--|
| Member ID No./ Employee ID (Client ID): E 1 A 8 4 | *Claim Intimation Service Request no.: 2 0 2 6 1 1 7 4 8 6 |
| Group/ Company name: A Y A N C E | Is this a renewal policy: Yes No |
| CONSULTING SERVICE PVT. | If Yes, kindly mention your previous policy no.: 2 0 2 6 1 1 7 4 8 |

4. Details of the Insured person in respect of whom claim is made: (patient details)

- Name of Insured: NEENAKSHI THAKUR
 Gender: Male ☐ Female ☒ Date of Birth: 15/10/1996 Completed age: Years 24 Months 02
 Occupation: Service ☒ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please specify) _____
 Are you previously covered by any other Mediclaim/ Health Insurance: Yes ☐ No ☒ If yes, Company name: _____
 Current residential address: 11-5-348/352, Flat no: 604, Arun apartments,
Redhills, Hyd- 500004
 City: HYDERABAD
 State: TELANGANA Pin code: 500004
 Mobile no. 7842147194 Landline no. _____
 E-mail: sonumeenakshisisingh@gmail.com

5. Nature of disease/ illness contracted or injury suffered for which Insured was hospitalized (Diagnosis): No.

- Name of hospital where admitted:
- Room category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐ Others
- Date of Admission: / / Time: : Date of Discharge: / / Time: :
- Date of injury sustained or disease/ Illness first detected: / /
- If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/ Alcohol consumption ☐ Others
- If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐ MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)
- System of Medicine:

6. Are you covered under any Topup/Additional policy : Yes ☐ No ☐ If yes, provide policy no. _____

7. **Currently covered by any other Medicaid/ Health Insurance:** _____ **Date of commencement of first Insurance without break:** _____

- Have you been hospitalized in the last 4 years since inception of contract: ☐ **Date:** / / **Dignosis:**
- Have you lodged any claim against this particular admission date/ attached bills with any other Insurance company: If yes, attach settlement letter,
Company name: Policy No. Sum Insured: ₹

8. Details of Claim

- a) Details of the treatment expenses claimed

i. Pre-hospitalization expenses:	₹	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ii. Hospitalization expenses:	₹	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii. Post-hospitalization expenses:	₹	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	iv. Health-check up cost:	₹	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
v. Ambulance charges:	₹	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	vi. Others _____:	₹	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
								Total:	₹	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
vii. Pre-hospitalization period		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Days							
								viii. Post-hospitalization period:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
								Days							

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032

Part - B (To be filled by Treating Doctor/ Hospital only)**1. Details of the Hospital/ Nursing home in which treatment was taken**

Name of the Hospital/ Nursing home: ARIES MATERNITY HOSPITAL
Address: #10-2-524 & 531, MCH COLONY, ASIF NAGAR
City: HYDERABAD State: TELANGANA
Pincode: 500025 Telephone no.: 04023591911 Mobile no.: 9951206555
Hospital ID: 07FAPMCE79 Type of Hospital: Network ☐ Non Network ☒ If Non Network, provide below details
Registration No. with State Code: 07FAPMCE79 PAN AAHF D3059M Number of Inpatient beds: 35
Facilities available in the hospital: OT: ☒ ICU: ☒

2. Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon

Name: DR. SEEMA DEVI GAUR
Qualification: MBBS, DGO Registration no.: AMC12378
Telephone no.: 040-23591914 Mobile no.: 9951206555

3. Details of the patient admitted

Name of the patient: MRS. MENAKSHI
IP Registration no.: 1443 Gender: ☒ Male ☐ Female Age: 24 Years 0 Months Date of Birth: 21/11/2020
Date of Admission: 21/11/2020 Time: 16:00 Date of Discharge: 27/11/2020 Time: 16:00
Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☒
Type of Treatment: Surgical Procedure ☐ Multiple Surgical Procedure ☐ Medical Treatment ☐
If Maternity, Date of Delivery: 21/11/2020 Gravida Status: G 1 P 0 A 0 L 0
Premature Baby: Yes ☐ No ☒
Status at time of discharge: Discharge to home ☒ Discharge to another hospital ☐ Deceased ☐
Total claimed amount: ₹ 000000

4. Details of the procedure

Pre-authorization obtained: Yes ☐ No ☐ If yes, Pre-authorization No.: 0000000000
If authorization by network hospital not obtained, give reason: 00/00/0000
Date of injury sustained or disease/ illness first detected: DD/MM/YYYY
If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/Alcohol consumption ☐ Others 0000
If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐ MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)
FIR no. 0000000000 If not reported to Police, give reason: 0000000000
If injury due to substance abuse/alcohol consumption, test conducted to establish this: Yes ☐ No ☐ (If yes, attach report)

5. This section is mandatory only if your health policy is not provided by your employer

A) Diagnosis (ICD 10 Code primary & additional diagnosis)	
i) Primary diagnosis (with ICD 10 code)	
ii) Additional diagnosis (with ICD 10 code)	
iii) Procedure diagnosis (with ICD 10 PCS code)	
B) Nature of surgery/ treatment given for present ailment	
C) Date of first consultation (Prior to hospitalization)	
D) Presenting complaints of the patient during admission	
E) Past medical history of the patient along with duration of illness (If yes, attach first & all past consultation paper)	
F) Was the patient under influence of alcohol during admission	
G) Whether the present treatment ailment is a complication of pre-existing disease?	
i) If yes, please specify the disease (or) complication of any previous surgery done?	
ii) If yes, please specify the details	
H) Whether the disease/ disorder is congenital in nature?	
I) Number of in-patient beds in the hospital (including ICU)	

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.

ARIES MATERNITY HOSPITAL

Registration No. of Hospital
(Rubber stamp of the hospital)

Date: DD/MM/YYYY

Doctor's Seal and Signature

As per the policy Terms and Conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.

b) Claim for

- i. Domiciliary Hospitalization: Yes ☐ No ☐ (If yes, provide details in annexure)
 ii. Day care: Yes ☐ No ☐
 iii. Extended care/ Inpatient rehabilitation: Yes ☐ No ☐

c) Details of lump sum/ cash benefit claimed:

- i. Hospital daily cash: ₹
 ii. Surgical cash: ₹
 iii. Critical illness: ₹
 iv. Convalescence: ₹
 v. Pre/ Post hospitalization lump sum benefit: ₹
 vi. Others: ₹

9. Details of the amount claimed

Bill heads (as applicable)	Bill number	Bill date	Bills attached	Amount
Room rent				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Doctors consultation/ Visit charges				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Investigation charges (Includes Radiology and Pathology reports)				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Surgeon and Asst. surgeon charges				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Anesthetist charges & Operation theatre charges				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Equipment charges/ Procedure charges				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Cost of implant (If any)				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medicine charges (Includes ward and OT medicines and consumables)				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Pharmacy charges				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Taxes/ Surcharges/ Service charge				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Miscellaneous/ Other charges				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Pre hospitalization bills (If any)				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Post hospitalization bills (If any)				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Discount provided by hospital (If any)				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents)				₹ 55000

MANDATORY: ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR). PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS. REFER TO PART C.

10. In support of the above claim, I enclose following documents in original (Please indicate by ticking in the Yes/ No column below)

Type of Document(s) - *Mandatory	Yes	No	Type of Document(s) - As Applicable	Yes	No
1. Claim form duly filled and signed*	<input type="checkbox"/>	<input type="checkbox"/>	9. ICICI Lombard GIC Authorisation Letter	<input type="checkbox"/>	<input type="checkbox"/>
2. Discharge summary*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Implant name and invoice (if any) with implant sticker	<input type="checkbox"/>	<input type="checkbox"/>
3. Hospital bills, Final/ main hospital bill and other bills (if any)*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Indoor Case Papers	<input type="checkbox"/>	<input type="checkbox"/>
4. Hospital payment receipt & other receipts supporting bills*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Prescription papers/ Consultation papers	<input type="checkbox"/>	<input type="checkbox"/>
5. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	<input type="checkbox"/>	<input type="checkbox"/>	13. Others (details) _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Medicine/ Pharmacy bills with doctors prescription*	<input type="checkbox"/>	<input type="checkbox"/>			
7. Age proof (Driving License/ PAN card/ Passport/ Aadhar copy)*	<input type="checkbox"/>	<input type="checkbox"/>			
8. Part - C (For EFT/RTGS/ NEFT)*	<input type="checkbox"/>	<input type="checkbox"/>	14. Part - D (KYC documents required if total claimed amt. is > ₹1 lakh)	<input type="checkbox"/>	<input type="checkbox"/>

*Mandatory.

Please attach all the documents as per above serial number. Films like x-ray film, CT Scan film, MRI Scan film, etc. are not required. Provide reports only

Declaration by the Insured:

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent and 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 and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, if any.

Date: 24/12/2020

Place: Hyderabad

Insured's Signature:

Heenakshi

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032

* Your Claim details are just an SMS away. Please SMS <KEYWORD> to 57 57 58

* Cashless Status: <KEYWORD> is "ILHC AL <12-digit-AL-No.>" * Claim Status: <KEYWORD> is "ILHC CL <12-digit-CL-No.>" * Payment details: <KEYWORD> is "ILHC PAY <12-digit-Claim-No.>"

(AL No. & CL No. is the one you have received on your mobile no. after intimating us)

* To view real time claim status, please click: <https://www.icicilombard.com/IL-Health-Care/Customer/ClaimStatus>

FORM VII (See Rule 6)
GOVERNMENT OF TELANGANA
HEALTH MEDICAL & FAMILY WELFARE DEPARTMENT
DISTRICT REGISTERING AUTHORITY

CERTIFICATE OF RENEWAL OF REGISTRATION OF ALLOPATHIC
PRIVATE MEDICAL CARE ESTABLISHMENT.

1. Application No. & Date : 1218 -27-11-2019
2. Inspection Report No. and Date : 0079- 29-11-2019
3. Original File No. of Registration Authority : 07F - APMCE - 0079
4. Date of Issue of the Certificate of Registration : 01-12-2009
5. Date of 1st Renewal of the Certificate of Registration : 01-12-2014
6. Date of 2nd Renewal of the Certificate of Registration : 01-12-2019
7. Renewal of Certificate of Registration valid upto : 30-11-2024
8. Name of the Owner / Applicant : Mr. JAYPAL SINGH,
MANAGING DIRECTOR
9. This is to Certify that M/s. DR. SEEMA'S ARIES MATERNITY HOSPITAL,
H.NO.10-2-524 & 531, OPP. CANARA BANK, UPSTAIRS MIRAZA STEEL, MCH
COLONY, ASIF NAGAR, HYDERABAD-500028 is hereby registered under the
provisions of T.S. Allopathic Private Medical Care Establishments Registration and
Regulation) Act 2002 to provide following medical care services.
10. Hereby registered under the provisions of T.S. Allopathic Private Medical Care
Establishments Registration and Regulation) Act 2002 to provide following medical care
services.

1. BASIC TYPES OF SERVICES
2. SPECIALITY TYPES OF SERVICES
3. DIAGNOSTIC TYPES OF SERVICES

11. This registration shall be in force for a period of 5 (five) years from the date of issue.
12. This Certificate shall be produced whenever it is required to the officer authorized by
the registration authority.
13. The establishment shall not lend, sell, transfer or otherwise close down the without
obtaining prior permission of the registration authority.
14. Any unauthorized change in personnel, equipment or working conditions as mentioned
in the application by the Establishment shall constitute a breach of registration.
15. The Establishment shall not violate the provision of *T.S. Allopathic Private Medical
Care Establishments Registration and Regulation) Act, 2002) as amended from time to
time and the rules made there under:*
16. This Certificate is subject to the conditions and the provisions of the T.S. Allopathic
Private Medical Care Establishments Registration and Regulation) Act, 2002.).

Dr. J. VENKATI, MBBS, DGO
District Medical & Health Officer &
Chairman, District Registering Authority, Hyderabad District
4th Floor, NTHC Building,
Opp. H. H. H. Bhavan, Secunderabad
District Medical & Health Officer
District Registering Authority &
District Medical & Health Officer
District T.S.

DISPLAY ONE COPY OF THE CERTIFICATE AT A CONSPICUOUS PLACE AT THE PLACE OF BUSINESS.

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR). PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS.

CLAIM DETAILS

Patient's Name: MEENAKSHI THAKUR
 (in respect of whom claim is made):
 Policy Number: 117900585000
 Card No./ UHID No.: 117900585000
 Group/Company Name (for Group/Corporate policy holders): AVANCE CONSULTING SERVICES PVT.LTD
 Claim Number (if allotted): 7842147194 Mobile/ Contact No.: 7842147194

As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT.

Please provide ANY ONE of the below documents of proposer/ policy holder-

- ☐ Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D)
- ☒ Cancelled cheque copy
- ☐ Bank attested copy of Passbook with IFSC code

Please provide the below details (all fields are compulsory)

BANK DETAILS

- Proposer/ policy holder name* (as per bank records): MEENAKSHI THAKUR
- Proposer/ policy holder Bank account no.: 037001525337
- Name of the bank: ICICI BANK
- Branch name: NALLAKUNTA BRANCH
- Address of the bank: 1-9-1114 to 1117, main road, Vidyanagar nallakunta, Hyderabad-500044
- IFSC code no. of the bank: ICIC00000370 (should be same as per the provided cheque leaflet)

*Proposer/ policy holder is the person who has paid premium for the policy. All the above details and document(s) should be of Proposer/ policy holder only.

Terms and Conditions for Payments through RTGS/ NEFT

1. The details provided by the Proposers/ policy holder in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Proposer(s)/ policy holder within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
3. The Proposer/ policy holder agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/ inaction/ failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Proposer/ policy holder agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. ICICI Lombard General Insurance Company Ltd. May sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Proposer/ policy holder may discontinue or terminate the use of RTGS/ NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd. The notice of, such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd., ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400025.
6. A confirmation of the receipt of termination notice given by the Proposer/ policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy holder.
7. The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy holder only.
8. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of ten days for such changes wherever feasible for the Terms and Conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Proposer/ policy holder shall be deemed to have accepted the changed Terms and Conditions.
9. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
10. Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/ policy holder.
11. These Terms and Conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
12. I/We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Proposer/ policy holder through any other source.
13. I/We agree that my/ our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers. This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Proposer/ policy holder.

Meenakshi

Account holder's Signature

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ICICI Lombard Healthcare,

Respected Sir/Madam,

I: Ashish Singh, H/o, ~~Mr~~ Meenakshi

Thakur, holding a health care policy with card no. IL17900585000, hereby I am dispatching the Hospital bill documents on 24/12/2020.

Since it is Christmas tomorrow and again Saturday and Sunday, I am not sure when it will be delivered, still I am requesting you to please consider it if gets little delayed also, would thankfull for a helping gesture. Thankyou. I am reachable on. 8801230400. You can reach me for any assistance.

Thankyou.

Ashish

(8801230400)



భారత విశిష్ట గుర్తింపు ప్రాధికార సంస్థ

భారత ప్రభుత్వం

Unique Identification Authority of India

Government of India

రిజిస్ట్రేషన్ / Enrolment No.: 2189/64009/74887

To

మీనాక్షి థాకూర్

Meenakshi Thakur

D/O Naveen Singh

14-11-67

Mangalhat

Kamati Pura

Nampally

Hyderabad Andhra Pradesh - 500012

7642147194

Generated Date: 26/11/2017

Generation Date: 27/10/2017



మీ ఆధార్ సంఖ్య / Your Aachaar No. :

4597 3443 5351

నా ఆధార్, నా గుర్తింపు



భారత ప్రభుత్వం

Government of India



మీనాక్షి థాకూర్

Meenakshi Thakur

జన్మ తేదీ/DOB: 15/10/1996

FEMALE



4597 3443 5351

నా ఆధార్, నా గుర్తింపు



Government of India



మూలాలు

- ఆధార్ గుర్తింపుకు దృవీకరణ, దానిని నిరసించే కాదు.
- గుర్తింపుకు దృవీకరణ ఆన్‌లైన్ అథెంటికేషన్ ద్వారా జరుపుకోవచ్చు.
- ఇది ఎలక్ట్రానిక్స్ పద్ధతిలో సృష్టించబడినది.

INFORMATION

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

- ఆధార్ దీక్షిమంతటా అమోదించబడుతుంది.
- ఆధార్ తినివేయటంలో ప్రభుత్వ మరియు ప్రభుత్వేతర ఏకల అందజేయడంలో సహాయ పడుతుంది.
- Aadhaar is valid throughout the country
- Aadhaar will be helpful in availing Government and Non-Government services in future.



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Unique Identification Authority of India

Address:

D/O Naveen Singh, 14-11-67,
Mangalhat, Kamati Pura,
Nampally, Hyderabad,
Andhra Pradesh - 500012

రిజిస్ట్రేషన్:

D/O Naveen Singh, 14-11-67,
Mangalhat, Kamati Pura,
Nampally, Hyderabad,
Andhra Pradesh - 500012

4597 3443 5351

0-3



ARIES MATERNITY HOSPITAL

10-2-524, 531, 532 & 533, Opp. Canara Bank, Upstairs Mirza Steel, M.C.H. Colony, Asif Nagar,
Hyderabad - 500 028. Ph : 23591911, 23591912, E-mail : seemasarieshospital@gmail.com

Detailed Bill

Patient Name	: MRS. MENAKSHI	IP No	: 1443
Age/Gender	: 24 Y / FEMALE	MR No	: 5540
Mobile No	: 6301131405	Bill No	: 20000509
Doctor	: Dr. SEEMA DEVI GAUR	Bill Date	: 26/11/2020 11:56 AM
Department	: GYNAECOLOGY AND OBSTETRICS	Admission Date	: 21/11/2020 4:00 PM
Ward/Bed No	: 3 FLOOR SINGLE NON-A/C ROOM / 307/B	Discharge Date	: 27/11/2020 4:00 PM
Source Type	: Hospital		

Date	Issue No	Code	Description	Mfg Nm	Batchno	Expirydt	Rate	Qty	Amount
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WARD CHARGES

3 FLOOR SINGLE NON-
A/C ROOM (21-11-20 to
27-11-20)

1500.00 6.00 9000.00

WARD CHARGES TOTAL: 9,000.00

SERVICES

OTHER SERVICES

25/11/2020	20025068		ANAESTHESIA				4000.00	1.00	4000.00
25/11/2020	20025068		ASSISTANT SURGEON 2				4000.00	1.00	4000.00
25/11/2020	20025068	IP REG	IP REGISTRATION				1050.00	1.00	1050.00
25/11/2020	20025068		N.S.T				300.00	1.00	300.00
25/11/2020	20025068		NIBP MONITORING				2000.00	1.00	2000.00
25/11/2020	20025068	NURS	NURSING CHARGES				600.00	6.00	3600.00
25/11/2020	20025068		OT CHARGES				3500.00	1.00	3500.00
25/11/2020	20025068		PAEDIATRICIAN				3000.00	1.00	3000.00
25/11/2020	20025068	PROF	PROFESSIONAL CHARGE				1200.00	6.00	7200.00
25/11/2020	20025068		SURGEON CHARGES				9000.00	0.00	0000.00

SERVICES TOTAL: 28,650.00

INVESTIGATIONS

BIOCHEMISTRY

25/11/2020	20025067		GRBS				100.00	4.00	400.00
25/11/2020	20025067	BILL	SERUM BILLIRUBIN				300.00	1.00	300.00
25/11/2020	20025067	SC	SERUM CREATENINE				150.00	1.00	150.00

HAEMATOLOGY

25/11/2020	20025067	GROUPING	BLOOD GROUPING				150.00	1.00	150.00
25/11/2020	20025067	CBP	COMPLETE BLOOD PICTURE				250.00	1.00	250.00

MICROBIOLOGY

25/11/2020	20025067		URINE ALBUMIN				100.00	2.00	200.00
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INVESTIGATIONS TOTAL: 1,450.00

PHARMACY

ISSUES TO PATIENT

25/11/2020	20784		2 SURGICAL TAPE	*****	****	30/01/2021	1000.00	1.00	1000.00
25/11/2020	20784		5D	EUROLIFE	10200095A/*	30/03/2023	33.44	2.00	66.88
25/11/2020	20784		AB GEL	SRI GOPAL KRISHNA LABS	060720/*	30/05/2023	160.00	1.00	160.00
25/11/2020	20784		ANAWIN HEAVY	NEON	FF005	30/12/2021	27.73	1.00	27.73
25/11/2020	20784		BETADINE SOLUTION	WIN-MEDICARE PVT LTD	*****	31/05/2025	105.00	1.00	105.00

Detailed Bill

Patient Name	: MRS. MENAKSHI	IP No	: 1443
Age/Gender	: 24 Y / FEMALE	MR No	: 5540
Mobile No	: 6301131405	Bill No	: 20000509
Doctor	: SEEMA DEVI GAUR	Bill Date	: 26/11/2020 11:56 AM
Department	: GYNAECOLOGY AND OBSTETRICS	Admission Date	: 21/11/2020 4:00 PM
Ward/Bed No	: 3 FLOOR SINGLE NON-A/C ROOM / 307/B	Discharge Date	: 27/11/2020 4:00 PM
Source Type	: Hospital		

Date	Issue No	Code	Description	Mfg Nm	Batchno	Expirydt	Rate	Qty	Amount
25/11/2020	20784		BOUFFANNT CAP	3M	*****	30/05/2025	15.00	15.00	225.00
25/11/2020	20784		BUPRIGESIC	NEON	4579***	28/02/2021	23.00	1.00	23.00
25/11/2020	20784		COTTON BALLS	***	*****/	20/08/2024	30.00	10.00	300.00
25/11/2020	20784		COZY SHEETS	MEDIKLIN	29092019**	30/12/2023	225.00	2.00	450.00
25/11/2020	20784		CUTARUB 500ML	***	*****	30/05/2025	845.00	1.00	845.00
25/11/2020	20784		DISPOSABLE PACK	***	***	30/05/2025	1499.00	1.00	1499.00
25/11/2020	20784		DIST. WATER	CLARIS	2200838//	26/02/2023	2.56	20.00	51.20
25/11/2020	20784		DNS	FRESINIUS	10200260C	30/06/2023	33.65	3.00	100.95
25/11/2020	20784		DRAPE SHEETS	PREMIUM HEALTHCARE	12.19	30/12/2024	60.00	3.00	180.00
25/11/2020	20784		DULCOFLEX (ADULT)	SANOFI	SA20024	30/05/2022	30.59	2.00	61.18
25/11/2020	20784		ELECTRO SURGICAL PENCIL	***	**/*	30/04/2023	701.00	1.00	701.00
25/11/2020	20784		EVATOCIN	NEON	091344**/*	30/11/2021	19.18	6.00	115.08
25/11/2020	20784		FACE MASK	ROMSONS SCIENTIFIC AND SURGICAL LTD	NISHANT**/*	28/02/2022	10.00	15.00	150.00
25/11/2020	20784		FEEDING TUBES	ROMSONS SCIENTIFIC AND SURGICAL LTD	*****	30/05/2025	55.00	5.00	275.00
25/11/2020	20784		FERENA	HOSPI NEEDS	**/*	31/10/2023	90.00	1.00	90.00
25/11/2020	20784		FOLEYS CATHETER	ROMSONS SCIENTIFIC AND SURGICAL LTD	G20062411	30/05/2025	141.00	1.00	141.00
25/11/2020	20784		GAUZE PADS	*****	*****	30/05/2022	35.00	10.00	350.00
25/11/2020	20784		INJ DYNAPAR	TROIKA PHARMACEUTICALS LTD	d105f147	30/05/2021	30.42	4.00	121.68
25/11/2020	20784		INJ GENTAMYCIN	ZYDUS HEALTHCARE LTD	MV2A60	30/12/2021	12.00	4.00	48.00
25/11/2020	20784		INJ NEOMIT	NEON	2538003	30/05/2022	12.90	4.00	51.60
25/11/2020	20784		INJ TAXIM 1GM	ALKEM HEALTHCARE	19461140*-	30/05/2022	37.59	6.00	225.54
25/11/2020	20784		INJEK 0.5ML	NEON	1255051	30/07/2021	21.20	1.00	21.20
25/11/2020	20784		INSULIN SYRINGE	HINDUSTAN SYRINGES AND MEDICAL DEVICES	0076657	30/03/2025	89.00	1.00	89.00
25/11/2020	20784		IV CANULA NO.20	ROMSONS SCIENTIFIC AND SURGICAL LTD	G20022388**/*	30/01/2025	138.00	1.00	138.00
25/11/2020	20784		IV FIX	STERIMEDS SURGICALS	N2003009	30/06/2023	50.00	1.00	50.00
25/11/2020	20784		IV SET	ROMSONS SCIENTIFIC AND SURGICAL LTD	841568	30/05/2024	138.00	1.00	138.00
25/11/2020	20784		KLIK CLAMP	ROMSONS SCIENTIFIC AND SURGICAL LTD	GRM20C512	28/02/2024	30.00	1.00	30.00
25/11/2020	20784		LOX 2% ANAWIN	NEON	NT144092	30/01/2021	31.90	1.00	31.90
25/11/2020	20784		LSCS PACKS	AMARYLIS HEALTHCARE	12409010719./*	26/11/2022	1300.00	1.00	1300.00
25/11/2020	20784		MEM	NEON	KP39051	30/01/2021	15.50	1.00	15.50
25/11/2020	20784		METROGYL IV	EUROLIFE/FRESINIUS	2202570***/*	30/06/2023	22.40	8.00	179.20
25/11/2020	20784		NS-100ML	EUROLIFE	295005	30/11/2022	17.33	1.00	17.33
25/11/2020	20784		PANTIN I.V	GENIX PHARMA	HAA20038**/*	30/04/2022	49.30	4.00	197.20



ARIES MATERNITY HOSPITAL

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Detailed Bill

Patient Name	: MRS. MENAKSHI	IP No	: 1443
Age/Gender	: 24 Y / FEMALE	MR No	: 5540
Mobile No	: 6301131405	Bill No	: 20000509
Doctor	: SEEMA DEVI GAUR	Bill Date	: 26/11/2020 11:56 AM
Department	: GYNAECOLOGY AND OBSTETRICS	Admission Date	: 21/11/2020 4:00 PM
Ward/Bed No	: 3 FLOOR SINGLE NON-A/C ROOM / 307/B	Discharge Date	: 27/11/2020 4:00 PM
Source Type	: Hospital		

Date	Issue No	Code	Description	Mfg Nm	Batchno	Expirydt	Rate	Qty	Amount
25/11/2020	20784		PATIENT GOWNS	IR SURGICALS	XSR0621**/	02/02/2022	350.00	1.00	350.00
25/11/2020	20784		PPH	MEYER ORGANICS PVT LTD	479SY2002**	30/06/2022	69.00	1.00	69.00
25/11/2020	20784		PREP RAZOR BLADE	***	XNSHNT0920	30/01/2023	45.00	2.00	90.00
25/11/2020	20784		RL 500ML	EUROLIFE/FRESINIUS	005213P	30/05/2022	50.68	7.00	354.76
25/11/2020	20784		SAFE HANDS	****	06.20	30/06/2025	24.60	20.00	492.00
25/11/2020	20784		SAMPLE BOTTLES	***	****	30/05/2021	55.00	1.00	55.00
25/11/2020	20784		SPINAL NEEDLES NO.25	BECKTON DICKISON	1911006	30/10/2024	162.00	1.00	162.00
25/11/2020	20784		SUCTION SET	ROMSONS SCIENTIFIC AND SURGICAL LTD	*****//	30/12/2024	680.00	1.00	680.00
25/11/2020	20784		SURGEON GOWNS STERILE	AMARYLLIN	****/	30/12/2023	650.00	2.00	1300.00
25/11/2020	20784		SURGI CARE GLOVE 7.5	SUTUERS	XPMT0820**/	30/04/2023	78.00	4.00	312.00
25/11/2020	20784		SURGICARE GLOVES 6 STERILE NO.		****/	30/11/2023	68.00	4.00	272.00
25/11/2020	20784		SURGICARE GLOVES 6.5 NO.	STERILE	2038828KV	30/05/2023	65.00	2.00	130.00
25/11/2020	20784		SURGICARE GLOVES 7 STERILE NO		***,	30/12/2024	78.00	2.00	156.00
25/11/2020	20784		SYRINGE 10ML	HINDUSTAN SYRINGES AND MEDICAL DEVICES	*****	30/05/2025	10.00	10.00	100.00
25/11/2020	20784		SYRINGE 2ML	HINDUSTAN SYRINGES AND MEDICAL DEVICES	042023NE-1	30/09/2023	4.50	15.00	67.50
25/11/2020	20784		SYRINGE 3ML	HINDUSTAN SYRINGES AND MEDICAL DEVICES	****/	30/12/2024	6.00	8.00	48.00
25/11/2020	20784		SYRINGE 5ML	HINDUSTAN SYRINGES AND MEDICAL DEVICES	*****	30/05/2025	6.00	12.00	72.00
25/11/2020	20784		TERMIN	UHB MEDISCIENCES	M45571*-/	30/07/2022	222.64	1.00	222.64
25/11/2020	20784		TRUGLYDE 2364	SUTUERS	E200842*	30/06/2025	606.00	1.00	606.00
25/11/2020	20784		TRUGLYDE SN 2347	SUTUERS	E200757P**/	30/05/2025	554.00	1.00	554.00
25/11/2020	20784		TRUGLYDE SN2472	SUTUERS	E200786P**/	30/05/2025	459.00	1.00	459.00
25/11/2020	20784		UROBAG	RAJ VIJAY CORPORATION	cn20f046	30/05/2024	266.00	1.00	266.00

PHARMACY TOTAL: 16,389.07

Detailed Bill

Patient Name	: MRS. MENAKSHI	IP No	: 1443
Age/Gender	: 24 Y / FEMALE	MR No	: 5540
Mobile No	: 6301131405	Bill No	: 20000509
Doctor	: SEEMA DEVI GAUR	Bill Date	: 26/11/2020 11:56 AM
Department	: GYNAECOLOGY AND OBSTETRICS	Admission Date	: 21/11/2020 4:00 PM
Ward/Bed No	: 3 FLOOR SINGLE NON-A/C ROOM / 307/B	Discharge Date	: 27/11/2020 4:00 PM
Source Type	: Hospital		

Rupees in words : FIFTY FIVE THOUSAND RUPEES ONLY

Receipt Details

SNo	Record date	Bill No	Receipt No	Amount	Payment Mode
-----	-------------	---------	------------	--------	--------------

Settlement

1	27/11/2020	27815 29038	55000	Cash
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Sub Total:	55000
Grand Total:	55000

Gross Total	: 55,489.07
Less Discount	: 489.07
Total GST	: 0.0
Net Bill Amount	: 55,000.00
Less Advance	: 0.00
Net Payable	: 55,000.00
Current Balance	: 0.00

Patient/Attendant Signatory



(IP No)

Bill date & Time : 26/11/2020 11:56 AM

Print Date & Time : 21/12/2020 11:14 AM

Prepared By : FOUZIA F



(Bill No)



ARIES MATERNITY HOSPITAL

10-2-524, 531, 532 & 533 Opp. Canara Bank, Upstairs Mirza Steel, M.C.H. Colony,
Asif Nagar, Hyderabad - 500 028. Ph. : 040-23591911/912.

DISCHARGE SUMMARY

IP No	: 1443	Admission Date & Time	: 21/11/2020
Name	: Mrs.MENAKSHI	Discharge Date & Time	: 27/11/2020
Age/Sex	: 24Years/Female	Doctor Name	: Dr.SEEMA DEVI GAUR
Relative Name	: W/O THAKUR ASHISH SINGH		

OBSTETRIC HISTORY: PRIMI GRAVIDA

EDD: 04.12.2020

ANTENATAL PERIOD:

- 1) Booked Patient
- 2) Regular ANC checkups
- 3) Took 2 doses of Inj. TT.
- 4) Surgical/Allergic History Nil.
- 5) H/O GDM on diet control.

ADMISSION DETAILS:

Patient admitted on 21.11.2020 at 04:00 PM at 38+1 weeks for Emergency LSCS in v/o Non -Reactive NST . At admission BP-110/70mmhg, PR-90/min, SPO2-98%. Urine Alb-negative, NST Suspicious pattern, V/E-CX-Long, OS-closed.

CAESAREAN DETAILS:

INDICATION : PFC
TYPE : Emergency
ANAESTHESIA : Spinal
& INCISION : Pfannenstiel
LUS : Stretched
LIQUOR : Meconium stained/ liquor
PLAC-SITE : Upper
UTERINE ANOMALY : Nil
BOTH OVARY & TUBE : Normal
*2 loops of cord around the neck.

POSTOPERATIVE PERIOD:

Post operative period was uneventful & patient got discharged on 27.11.2020.
*I/V Antibiotics X 48 hours.
*Post Op Thromboprophylaxis given.

ADVICE AT DISCHARGE:

- 1) Tab. Taxim 200mg o---o*5days.
- 2) Tab. Flagyl 400mg o---o*5days.
- 3) Tab. Pantop 40mg --o--*5days.
- 4) Tab. Dolo 650mg o---o---o *5days.
- 5) Tab. Livogen o---o--*3months.
- 6) Tab. Sandocal o--o* Till breast feeding.
- 7) Metrogyl ointment for L/A.
- 8) Tab. Chymoral forte o--o x10days.
- 9) Tab. Limcee o--o x 10days.
- 10) Review after 10 days for checkup.
- 11) Pap smear X 6 weeks.
- 12) Cap Intoto 60k (Once/ week) X 3 months.
- 13) Crepe bandage.
- 14) Contraception x 2-3yrs.
- 15) OGTT > 6 weeks.

DISCHARGE SUMMARY

IP No	: 1443	Admission Date & Time	: 21/11/2020
Name	: Mrs.MENAKSHI	Discharge Date & Time	: 27/11/2020
Age/Sex	: 24Years/Female	Doctor Name	: Dr.SEEMA DEVI GAUR
Relative Name	: W/O THAKUR ASHISH SINGH		

INVESTIGATIONS:

"B"+VE

30/09/2020

HB-10.3%gm

PLT-3.7lakhs

HBA1C-4.5

Urine for c/s-Candida

10/11/2020

HB-10.8gm%

PLT-3.5lakhs

Urine for c/s-Neg

HBA1C-5.5%

SrTSH-1.6miu/ml

HIV I & II-Negative

HBSAG-Negative

22/01/2020

HB-11.2gm%

PLT-2.7lakhs

Sr createnine-0.9mg/dl

BABY DETAILS:

1)BABY DATE OF BIRTH :21/11/2020

2)TIME OF BIRTH :05:19 PM

3)SEX :MALE BABY

4)WT OF THE BABY :3.5KGS

5)Inj.Vit.K 1mg given.

6)Mode of Delivery – Emergency LSCS @ 38+1 weeks in v/o PFC (PRIMI GRAVIDA)

7)GRBS-64mg/dl on 21.11.2020 @ 05:25PM.

8) GRBS-47mg/dl on 21.11.2020 @ 10:00PM.

9) GRBS-70mg/dl @01:00 AM on 22.11.2020.

11) GRBS-74mg/dl @08:00 AM on 22.11.2020.

12) GRBS-77mg/dl @ 12:00 PM on 23.11.2020.

Advice at Discharge:

1)Syp. OSSOPAN -D 2.5ml Twice in a day*1 month.

2)BETADINE POWDER for Local application. Thrice in a day *1 week.

3)HEALTH OK DROPS 0.5ml Once in a day *1month.

4)Review after 2 days at OPD between 12.30PM to 2.30PM.

5)Vaccination to be followed as advised

Sayeeda Afreen
27/11

KYC is required only for Individual/ Retail policy holders if the total claimed amount exceeds ₹ 100,000.

Patient's Name:
(in respect of whom claim is made):

Policy Number:

Card No./ UHID No.

Group/Company Name (for Group/Corporate policy holders):

Claim Number (if allotted) Mobile/ Contact No

The below KYC documents are mandatory as per AML guidelines by IRDA

1. ☐ Two passport size photos of Proposer (stick in the space provided below)
2. ☐ One photocopy of proof of identity of Proposer (any 1 in the below list)
3. ☐ One photocopy of proof of residence of Proposer (any 1 in the below list)

Proof of Identity (Any one of below mentioned documents required)	Proof of Residence (Any one of below mentioned documents required)
<input type="checkbox"/> Passport	<input type="checkbox"/> Electricity bill
<input type="checkbox"/> PAN card	<input type="checkbox"/> Ration card
<input type="checkbox"/> Voter's Identity card	<input type="checkbox"/> Letter from any recognized public authority
<input type="checkbox"/> Driving license	<input type="checkbox"/> Current statement of bank account with details of permanent/ present residence address (as downloaded)
<input type="checkbox"/> Personal identification and certification of the employees of the insurer for identity of the prospective policyholder.	<input type="checkbox"/> Current passbook with details of permanent/present residence address (updated upto the previous month)
<input checked="" type="checkbox"/> Letter issued by Unique Identification Authority of India containing details of name, address and Aadhar number.	<input type="checkbox"/> Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof.
<input type="checkbox"/> Job card issued by NREGA duly signed by an officer of the State Government	<input type="checkbox"/> Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract
<input type="checkbox"/> Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer	<input type="checkbox"/> Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)

Proofs of (both) Identity and Residence

- ☐ Passport
- ☐ Written confirmation from the banks where the prospect is a customer, regarding identification and proof of residence.
- ☐ Current passbook with details of present/ permanent residence address (updated to the previous month)
- ☐ Current statement of Bank account with details of present/ permanent residence address (as downloaded)

Stick Proposer's Photographs


Heenatshi

Claimant's Signature



ARIES MATERNITY HOSPITAL

10-2-524, 531,532,533, Opp. Canara Bank, Upstairs Mirza Steel, M.C.H. Colony, AsifNagar,
Hyderabad - 500028. Ph. : 23591911, 23591912

Final Money Receipt

IP No	: 1443	Doctor	: Dr. SEEMA DEVI GAUR
MR No	: 5540	Trans Type	: After Settlement
Name	: Mrs. MENAKSHI	Receipt No	: 29038
Age/Gender	: 24 Y / Female	Date	: 27/11/2020 4:02 PM
		Bed No	: 306/B

IP Advance

Amount of Rs. 55000/-

Payment Type	: Cash
Amount	: 55000.00
Amount In Words	: RUPEES FIFTY FIVE THOUSAND ONLY

Created By: FOUZIA



(IP No)

Bill Date & Time : 27/11/2020 4:02 PM
Print Date & Time : 21/12/2020 11:33 AM

Authorized Signatory



(BILL No)