

# Mandate Form for Electronic Clearance System

MD  
inDin

Policy Number	M D I 5 0 0 3 0 2 2 S 6 S 3							
IDID / EMP Number	5 2 9 7 6							
Claim Number								
Policy Holder Name	K H U S H B O O							
Telephone Number	7 0 1 1 8 6 9 5 3 0	Email ID						
Name of Account Holder	K H U S H B O O							
Name of Bank	H D F C B A N K							
Panach Name	K A R O L B A G H							
Panach Address	1 6 1 1 0 1 6 4 P A D A M S I N G H R O A D							
Type of Account:	S A V I N G							
Account Number	5 0 1 0 0 2 7 0 2 7 0 6 7 5	Cancelled Cheque	<input type="checkbox"/> Y	<input type="checkbox"/> N				
IFSC Code		IFSC Code	H D F C 0 0 0 2 3 1 7					

## Declaration:-

1. I hereby declare that the information furnished in this ECS Form is true & correct to the best of my knowledge & belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited.
2. I agree that I shall not hold TPA/Insurance Company responsible for delay or non-receipt of the payment for any reason whatsoever after issue of the instructions for payment by Insurer/TPA based on the above.
3. As per the revised RBI guidelines, Canceled cheque should have pre-printed name of account holder.

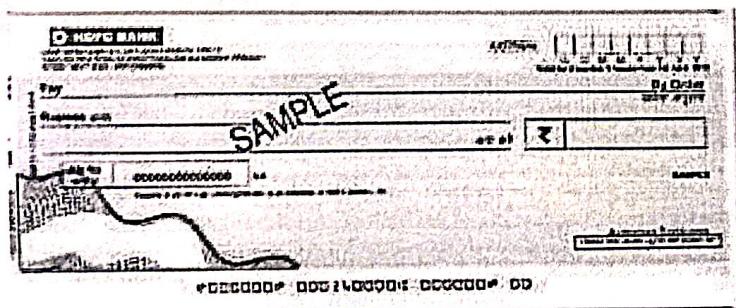
Date:

Place:

Signature of the Policy Holder

## -----SAMPLE CHEQUE FORMAT-----

Note: Claims Number / Policy number / MDID number to be mentioned on cancel cheque and Please enclose the cancelled cheque of your bank account for our record; your banker should be a participant of NEFT/RTGS Facility.



Claim No - M D I 5 0 0 3 0 2 2 S 6 S 3  
 OR  
 MDID No - MDI5-0000xxxx  
 OR  
 Policy No - XXXXXX/XX/XX/XXXXXX

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**

**(To be Filled In block letters)**

**DETAILS OF PRIMARY INSURED:**

a) Policy No.: <b>M 115002N225653</b>	b) Sl. No/ Certificate no. <b>                  </b>
c) Company/ TPA ID No: <b>                  </b>	<b>SURNAME</b> <b>KHUSHI ME</b> <b>MIDDLE NAME</b> <b>                  </b>
d) Name: <b>                  </b>	<b>                  </b>
e) Address: <b>105 AIMS GREEN AVENUE</b>	<b>City:</b> <b>NOTIDA EXTENSION</b> <b>State:</b> <b>UTTAR PRADESH</b>
Pin Code <b>201309</b>	Phone No: <b>                  </b>
	Email ID: <b>                  </b>

**DETAILS OF INSURANCE HISTORY:**

a) Currently covered by any other Mediclaim / Health Insurance: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) Date of commencement of first Insurance without break: DD MM YY YY YY
c) If yes, company name: <input type="text"/>	Policy No. <input type="text"/>
Sum Insured (Rs.) <input type="text"/>	d) Have you been hospitalized in the last four years since Inception of the contract? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis: <input type="text"/>	e) Previously covered by any other Mediclaim /Health insurance :: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

**Diagnosis:**

a) Previously covered by any other Mediclaim /Health insurance ::  Yes  No

If yes, company name: \_\_\_\_\_

**DETAILS OF INSURED PERSON HOSPITALIZED::**

**DETAILS OF HOSPITALIZATION:**

**ii) Reported to Police**

**DETAILS OF CLAIM:**

**DETAILS OF BILLS ENCLOSED:**

DETAILS OF BILLS ENCLOSED:										Amount (Rs)		
Sl. No.	Bill No.	Date					Issued by	Towards				
		D	D	M	M	Y		Hospital main Bill	Pre-hospitalization Bills: Nos	Post-hospitalization Bills: Nos		
1.		D	D	M	M	Y	Y					
2.		D	D	M	M	Y	Y					
3.		D	D	M	M	Y	Y					
4.		D	D	M	M	Y	Y					
5.		D	D	M	M	Y	Y					
6.		D	D	M	M	Y	Y					
7.		D	D	M	M	Y	Y					
8.		D	D	M	M	Y	Y					
9.		D	D	M	M	Y	Y					
10.		D	D	M	M	Y	Y					

**NAME OF PRIMARY INSURED'S BANK ACCOUNT:**

a) PAN: F A T U P K O G M 1 1 M b) Account Number: 5 0 1 0 0 2 7 0 2 7 0 6 4 5  
c) Bank Name and Branch: I N D I A N I S L A M I C B A N K  
d) Cheque / DD Payable details: \_\_\_\_\_ e) IFSC Code: I U M 0 0 0 0 1 3 1 7

**(IMPORTANT: PLEASE TURN OVER)**

## 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 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 & 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.

SECTION H

Date      Place:  NOIDA

Signature of the Insured

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

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF PRIMARY INSURED</b>		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
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
<b>SECTION B - DETAILS OF INSURANCE HISTORY</b>		
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-format
c) Company Name Policy No.	Enter the full name of the Insurance Company	Name of the organization in full
Sum insured	Enter the policy number	As allotted by the Insurance Company
d) Have you been Hospitalized in the last four years since Inception of the contract?	Enter the total sum insured as per the policy	In rupees
Date	Indicate whether hospitalized in the last four years	Tick Yes or No
Diagnosis	Enter the date of Hospitalization	Use mm-yy format
e) Previously covered by any other Mediclaim / Health Insurance?	Enter the diagnosis details	Open Text
f) Company Name	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
	Enter the full name of the Insurance Company	Name of the organization in full
<b>SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED</b>		
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
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
<b>SECTION D - DETAILS OF HOSPITALIZATION</b>		
a) Name of Hospital where admitted	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) Time	Enter time of discharge	Use hh-mm- format
i) 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
j) System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
<b>SECTION E - DETAILS OF CLAIM</b>		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	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
<b>SECTION F - DETAILS OF BILLS ENCLOSED</b>		
Indicate which bills are enclosed with the amount in rupees		
<b>SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT</b>		
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
c) 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
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
<b>SECTION H - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

## DETAIL BILL



**Bill No** :  
**UHID** : UHID232402207  
**Doctor** : DR SHWETA GOSWAMI  
**Company** : SELF  
**DOA** : 16-Oct-2024 04:06 PM  
**Patient Name** : Khushboo  
**Address** : Greater Noida ,Noida,Uttar Pradesh,INDIA  
**Marital Status** : Married

**Bill Date** :  
**ID** : NIP242501595  
**Ward/Unit/Bed** : IVF/1  
**DOD** :  
**Guardian Name** :  
**Age/Sex** : 30/Female

Sr No	Date	Code	Service Name	Doctor	Rate	Qty	Net Charge
<b>1 CONSULTATION</b>							
	16-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	19-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	21-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	23-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	24-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	26-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	28-Oct-2024	SR0613	FET CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
					<b>Total:</b>		<b>0.00</b>
<b>2 INVESTIGATION</b>							
	16-Oct-2024	SR00035	HbA1c Glycated Haemoglobin	DR SHWETA GOSWAMI	500.00	1	500
	16-Oct-2024	SR00063	HPLC / Thallasaemia Screen	DR SHWETA GOSWAMI	1000.00	1	1000
	16-Oct-2024	SR00064	TSH Reflex	DR SHWETA GOSWAMI	415.00	1	415
	16-Oct-2024	SR00066	E2 Estradiol	DR SHWETA GOSWAMI	650.00	1	650
	16-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	16-Oct-2024	SR00067	Progesterone (P4)	DR SHWETA GOSWAMI	700.00	1	700
	19-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	21-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	23-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	23-Oct-2024	SR00066	E2 Estradiol	DR SHWETA GOSWAMI	650.00	1	650
	23-Oct-2024	SR00042	LH-Luteinizing Hormone	DR SHWETA GOSWAMI	600.00	1	600
	23-Oct-2024	SR00045	Pre-Operative Profile-1	DR SHWETA GOSWAMI	1980.00	1	1980
	23-Oct-2024	SR00048	SGOT AST	DR SHWETA GOSWAMI	160.00	1	160
	23-Oct-2024	SR00049	SGPT ALT	DR SHWETA GOSWAMI	160.00	1	160
	24-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	26-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	28-Oct-2024	SR0614	FET FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	28-Oct-2024	SR00067	Progesterone (P4)	DR SHWETA GOSWAMI	700.00	1	700
	28-Oct-2024	SR00066	E2 Estradiol	DR SHWETA GOSWAMI	650.00	1	650
					<b>Total:</b>		<b>8165.00</b>

Operator: TARUN

PrintDate: 28-Oct-2024 04:28 PM

Hospital Charge	8165.00
Pharmacy Charge	
Hospital Discount	0.00
Net Charge	8,165.00
Received Amount	8,165.00
Refund Amount	0.00
Due On Bill	0.00



## DETAIL BILL



Bill No :  
 UHID : UHID232402207  
 Doctor : DR SHWETA GOSWAMI  
 Company : SELF  
 DOA : 16-Oct-2024 04:06 PM  
 Patient Name : Khushboo  
 Address : Greater Noida ,Noida,Uttar Pradesh,INDIA  
 Marital Status : Married  
 Bill Date :  
 ID : NIP242501595  
 Ward/Unit/Bed : IVF/1  
 DOD :  
 Guardian Name :  
 Age/Sex : 30/Female

Sr No	Date	Code	Service Name	Doctor	Rate	Qty	Net Charge
<b>1 CONSULTATION</b>							
	16-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	19-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	21-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
	23-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1	0
<b>Total:</b>							<b>0.00</b>
<b>2 INVESTIGATION</b>							
	16-Oct-2024	SR00035	HbA1c Glycated Haemoglobin	DR SHWETA GOSWAMI	500.00	1	500
	16-Oct-2024	SR00063	HPLC / Thalassaemia Screen	DR SHWETA GOSWAMI	1000.00	1	1000
	16-Oct-2024	SR00064	TSH Reflex	DR SHWETA GOSWAMI	415.00	1	415
	16-Oct-2024	SR00066	E2 Estradiol	DR SHWETA GOSWAMI	650.00	1	650
	16-Oct-2024	SR00067	Progesterone (P4)	DR SHWETA GOSWAMI	700.00	1	700
	16-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	19-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	21-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	23-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1	0
	23-Oct-2024	SR00066	E2 Estradiol	DR SHWETA GOSWAMI	650.00	1	650
	23-Oct-2024	SR00042	LH-Luteinizing Hormone	DR SHWETA GOSWAMI	600.00	1	600
	23-Oct-2024	SR00045	Pre-Operative Profile-1	DR SHWETA GOSWAMI	1980.00	1	1980
	23-Oct-2024	SR00048	SGOT AST	DR SHWETA GOSWAMI	160.00	1	160
	23-Oct-2024	SR00049	SGPT ALT	DR SHWETA GOSWAMI	160.00	1	160
<b>Total:</b>							<b>6815.00</b>

Operator: TARUN

PrintDate: 23-Oct-2024 04:26 PM

Hospital Charge	6815.00
Pharmacy Charge	
Hospital Discount	0.00
Net Charge	6,815.00
Received Amount	6,815.00
Refund Amount	0.00
Due On Bill	0.00

## Online Receipt



Receipt No : APPH242500729 Date : 21-Oct-2024  
UHID : UHID232402207 Gender/Age : Female/30 Years  
Patient Name : Khushboo Company : SELF  
Bank Name : PAYTM Branch : Sec 63 Noida

(Receiver's Signature)

Net Amount: Advance Payment 20000.00/-  
Rupees In Words : Rupees Twenty Thousand Only

User: DINESH KUMAR

Print Date : 21-Oct-2024 04:06 PM





## Advance Online Receipt

**Receipt No :** APKM242500687**Date :** 16-Oct-2024**UHID :** UHID232402207**Gender/Age :** Female/30 Years**Patient Name :** Khushboo**Branch :** Sec 63 Noida**Company :** SELF**Bank Name :** PAYTM**(Receiver's Signature)****Net Amount:** Advance Payment 10000/-**Rupees In Words :** Rupees Ten Thousand Only**User:** TARUN**Print Date :** 16-Oct-2024 04:05 PM

+91 83778 55100



Info@zeeva.in

www.zeevafertility.com

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.HA 103A, First Floor, Sector 104, Noida-201304



# Investigation/Procedure Receipt

Token No	: 1	Receipt No	: CKM242508124
Date	: 23-Oct-2024 04:05 PM	OPID	: NOP242506533
UHID	: UHID242501370	Age/Gender	: 31 Years/Male
Name	: Jay Shankar Bhatt	Credit Company	: SELF
Mobile No	: 9983083002	Department	: Andrology
Doctor	: ANDROLOGY LAB SEC 63		
Sr No	Code	Service	Doctor
1	SR0593	SEMEN CULTURE	ANDROLOGY LAB SEC 63
2	SR00523	SEMEN ANALYSIS	ANDROLOGY LAB SEC 63
Payment Type	: Debit Card	Bank Name	: PAYTM
Reference No	: 8448	Total Amt	: ₹ 1800/-
		Discount Amt	: ₹ 0/-
		Net Amount	: ₹ 1800/-
		Paid Amt	: ₹ 1800/-
		Balance Amt	: ₹ 0/-
		Refund Amt	: ₹ 0/-
		Payment Mode	: Online
User :	TARUN	In Words :	One Thousand Eight Hundred Only
		Print Date :	23-Oct-2024 04:05 PM

## Online Receipt



Receipt No : APPH242509708

Date : 16-Oct-2024

Gender/Age : Female/30 Years

UHID

Patient Name

Khushboo

Company

SELF

Bank Name

PAYTM

Branch : Sec 63 Noida

(Receiver's Signature)

Net Amount: Advance Payment 10000.00/-  
Rupees In Words: Rupees Ten Thousand Only

User: HANMESH KUMAR

Print Date : 16-Oct-2024 04:17 PM





## DETAIL BILL



Bill No :  
 UHID : UHID232402207  
 Doctor : DR SHWETA GOSWAMI  
 Company : SELF  
 DOA : 16-Oct-2024 04:06 PM  
 Patient Name : Khushboo  
 Address : Greater Noida ,Noida,Uttar Pradesh,INDIA  
 Marital Status : Married      Age/Sex : 30/Female

Sr No	Date	Code	Service Name	Doctor	Rate	Qty	Net Charge
<b>1 CONSULTATION</b>							
16-Oct-2024	SR0618	IVF CONSULTATION	DR SHWETA GOSWAMI	0.00	1		0
						<b>Total:</b>	<b>0.00</b>
<b>2 INVESTIGATION</b>							
16-Oct-2024	SR0619	IVF FOLLICULAR SINGLE ULTRASOUND	DR SHWETA GOSWAMI	0.00	1		0
16-Oct-2024	SR00064	TSH Reflex	DR SHWETA GOSWAMI	415.00	1		415
16-Oct-2024	SR00035	HbA1c Glycated Haemoglobin	DR SHWETA GOSWAMI	500.00	1		500
16-Oct-2024	SR00066	E2 Estradiol	DR SHWETA GOSWAMI	650.00	1		650
16-Oct-2024	SR00067	Progesterone (P4)	DR SHWETA GOSWAMI	700.00	1		700
16-Oct-2024	SR00063	HPLC / Thalassaemia Screen	DR SHWETA GOSWAMI	1000.00	1		1000
						<b>Total:</b>	<b>3265.00</b>

Operator: ALISHMA

PrintDate: 16-Oct-2024 04:38 PM

Hospital Charge	3265.00
Pharmacy Charge	0.00
Hospital Discount	0.00
Net Charge	3,265.00
Received Amount	3,265.00
Refund Amount	0.00
Due On Bill	0.00



# Advance Online Receipt



**Receipt No** : APKM242500726  
**UHID** : UHID232402207  
**Patient Name** : Khushboo  
**Company** : SELF  
**Bank Name** : PAYTM

**Date** : 28-Oct-2024  
**Gender/Age** : Female/30 Years  
**Branch** : Sec 63 Noida

(Receiver's Signature)

**Net Amount:** Advance Payment 50000/-  
**Rupees In Words :** Rupees Fifty Thousand Only

User: TARUN

Print Date : 28-Oct-2024 04:26 PM



**CLAIM FORM - PART B**

**TO BE FILLED IN BY THE HOSPITAL**  
The Issue of this Form Is not to be taken as an admission of liability  
Please include the original preauthorization request form in lieu of PART A

(To be Filled In block letters)

### DETAILS OF HOSPITAL

- a) Name of the hospital: **ZEEVA HEALTHCARE**

b) Hospital ID: **1234567890**

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

c) Name of the treating doctor: **GOSWAMI RISHABH NAMEMIDDLENAME**

e) Qualification: **MBBS, MS (Obs of Gynaec)** f) Registration No. with State Code: **UPNC91008** g) Phone No. **9560801635**

**FNB**

**DETAILS OF THE PATIENT ADMITTED**

- |                                 |                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                                    |                       |                                                                                                                                           |                     |                                                                                             |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------|
| a) Name of the Patient:         | <input type="text"/> S U R N A M E <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> K H U S H B O O M F <input type="text"/> <input type="text"/> M I D D L E <input type="text"/> N A M E <input type="text"/> |                         |                                                                                                                                                                    |                       |                                                                                                                                           |                     |                                                                                             |
| b) IP Registration Number:      | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>                                                                                                                                                                | c) Gender:              | Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>                                                                                           | d) Age: Years         | <input type="text"/> Y <input type="text"/> Y Months <input type="text"/> M <input type="text"/> M                                        | e) Date of birth:   | <input type="text"/> 3 <input type="text"/> 0 <input type="text"/> C <input type="text"/> 8 |
| f) Date of Admission:           | <input type="text"/> 3 <input type="text"/> 0 <input type="text"/> 4 <input type="text"/> 2 <input type="text"/> 4                                                                                                                                                                           | g) Time:                | <input type="text"/> H <input type="text"/> H <input type="text"/> M <input type="text"/> M                                                                        | h) Date of Discharge: | <input type="text"/> 3 <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 4                        | i) Time:            | <input type="text"/> H <input type="text"/> H <input type="text"/> M <input type="text"/> M |
| j) Type of Admission:           | Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Day Care <input checked="" type="checkbox"/> Maternity <input type="checkbox"/>                                                                                                                                          | k) If Maternity         |                                                                                                                                                                    | l) Date of Delivery:  | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y | ii) Gravida Status: | <input type="text"/> <input type="text"/> <input type="text"/>                              |
| j) Status at time of discharge: | Discharge to home <input type="checkbox"/> Discharge to another hospital <input type="checkbox"/> Deceased <input type="checkbox"/>                                                                                                                                                          | m) Total claimed amount | <input type="text"/> 1 <input type="text"/> 1 <input type="text"/> 1 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 5 <input type="checkbox"/> |                       |                                                                                                                                           |                     |                                                                                             |

**DETAILS OF AILMENT DIAGNOSED (PRIMARY)**

	ICD 10 Codes	Description		ICD 10 PCS	Description
I. Primary Diagnosis	<input type="text"/>	<i>Primary Infertility</i>		<input type="text"/>	
ii. Additional Diagnosis:	<input type="text"/>			<input type="text"/>	
iii. Co-morbidities:	<input type="text"/>			<input type="text"/>	
iv. Co-morbidities:	<input type="text"/>			<input type="text"/>	
			iv. Details of Procedure:	<i>Ovum pick up</i>	

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

**CLAIM DOCUMENTS SUBMITTED - CHECK LIST**

- |                                                                                |                                                                                |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Claim Form duly signed                                | <input type="checkbox"/> Investigation reports                                 |
| <input type="checkbox"/> Original Pre-authorization request                    | <input type="checkbox"/> CT/MR/USG/HPE investigation reports                   |
| <input type="checkbox"/> Copy of the Pre-authorization approval letter         | <input type="checkbox"/> Doctor's reference slip for investigation             |
| <input type="checkbox"/> Copy of Photo ID Card of patient Verified by hospital | <input type="checkbox"/> ECG                                                   |
| <input type="checkbox"/> Hospital Discharge summary                            | <input type="checkbox"/> Pharmacy bills                                        |
| <input type="checkbox"/> Operation Theatre Notes                               | <input type="checkbox"/> MLC reports & Police FIR                              |
| <input type="checkbox"/> Hospital main bill                                    | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break-up bill                                | <input type="checkbox"/> 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 | <b>N I A T B S E C T O R - 63</b> | <b>N O P D A</b> | <b>C I T Y</b>              | <b>G A U T A M B U D D H A N A G A R</b> | <b>S T A T E:</b>                       | <b>U T T A R P R A D E S H</b>                                                                                                                           |
| City:                      |                                   |                  |                             | State:                                   |                                         |                                                                                                                                                          |
| Pin Code:                  | <b>2 0 1 3 0 1</b>                | b) Phone No.     | <b>9 5 6 0 8 0 1 6 3 5</b>  |                                          | c) Registration No. with State Code:    | <b>A T T A C H E D</b>                                                                                                                                   |
| d) Hospital PAN:           | <b>A A B F Z 6 3 8 1 N</b>        |                  | e) Number of Inpatient beds | <b>0 0 2</b>                             | f) Facilities available in the hospital | i. OT <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No    ii. ICU <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| iii. Others:               |                                   |                  |                             |                                          |                                         |                                                                                                                                                          |

**DECLARATION BY THE HOSPITAL**

**(PLEASE READ VERY CAREFULLY)**

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

Date: ୦୮ ୧୯୯୫

### **Structure and Cost of the Hospital Attached**

any false or untrue statement, suppression or concealment of any material fact,  
**DR. SHWETA GOSWAMI**  
MBBS, MS (Obs & Gynae) FNB  
UPMC REGISTRATION No.-91008

Date: 08<sup>th</sup> Nov 2024**TO WHOMSOEVER IT MAY CONCERN**

The following is the breakup of the patient Procedure package (**IVF**) & package exclusions have been billed extra.

**Patient Name:** Mrs. Khusboo

**UHID:** UHID232402207

<b>IVF Package Breakup</b>	
Room Rent	3500.00
Surgeon fee	38000.00
Anesthesia fee	15200.00
Lab Consumables	24099.00
PAC	1000.00
Consultations	4800.00
OT Charges	13300.00
Ultrasound Charges	5000.00
OT Consumables	5101.00
Diet charges	1000.00
<b>Total</b>	<b>111000.00</b>



Zeeva Healthcare  
H 1 A/37 | Sector- 63 | Noida | UP -201301



+91 83778 55100

Info@zeeva.in  
www.zeevafertility.comH1A/37, Sector 63, Noida, Uttar Pradesh 201301 | FF-133B, Mahagun Mart Mall, Gaur City 2  
HA 103A, First Floor, Sector 104, Noida-201304. J-65, Patel Nagar 1, Ghaziabad, Uttar Pradesh - 201001



IPID	: NIP242501709	UHID	: UHID232402207
Patient Name	: Khushboo	Mobile	: 9983083002
Age	: 30 Years	Sex	: Female
Date & Time Of Admission	: 30-Oct-2024 09:30 AM	Date & Time Of Discharge	: 31-Oct-2024 01:22 PM
Consulting Doctor	: DR SHWETA GOSWAMI	Specialty	: Infertility And Ivf
Husband Name	: Jay Shankar Bhatt		

## Discharge Summary

**Type of Discharge Summary** : Discharge Summary

LMP	: 16-Oct-2024		
Procedure Done	: OVUM PICK UP UNDER GA		
Procedure Date	: 30-Oct-2024		
Protocol Used	: ANTAGONIST		
Stimulation	: INJ. IVF- M		
No of Oocytes	: 6		
Right Ovary	: 3	Left Ovary	: 3
Endometrial Lining	: 10.3 mm		
Trigger	: DECAPEPTYL		
Mock ET	: EASY		
Provisional Diagnosis	: PRIMARY INFERTILITY		

**General Examination**

Pulse(min)	: 74/MIN	B.P (mmHg)	: 120/80
SPO2(%)	: 99%		
R.S.	: 20/MIN		

**Condition of patient at Discharge**

: STABLE AND SATISFACTORY

**Drug Advice**

Sr No	Particulars	Req	Mor	Aft	Nit	Days	Medicine Advise	Remarks
1	TAXIM O 200	10	0	0	0	5		Twice a day
2	CAP SUSTEN 400 MG	10	0	0	0	5		ONE CAP TWICE DAILY (INTRAVAGINALLY)



3	PAN D CAP	10	0	0	0	5		Twice a day
4	COMBIFLAM	1	0	0	0	0		SOS
5	SYP LOOZ	1	0	0	0	0		30 ML AT BED TIME IF CONSTIPATION (SOS)
6	CABERNORM 0.5 MG TAB	7	0	0	0	7		Once a day

**Drug Advice**      7) TAB THYRONORM AND GLYCOMET IF TAKEN OR ADVISED.

**Follow Up Date :**      07-Nov-2024

**Created By :** HEMANT

Signature of RMO \_\_\_\_\_

Name & Signature of Patient / Attendant \_\_\_\_\_

DR. SHWETA GOSWAMI  
MBBS, MS (obs & Gynae) FNB  
UPMC REGISTRATION No.-91008  
Signature  
DR SHWETA GOSWAMI  
Infertility And Ivf

Please report back with this discharge summary to your physician for your follow up check up. Prior appointment to be taken for follow up by calling on 8377855100. In case of emergency please contact Dr.Parul Sharma 9560801449.

**Created Date :** 30-Oct-2024 01:28



Date: 08<sup>th</sup> Nov 2024

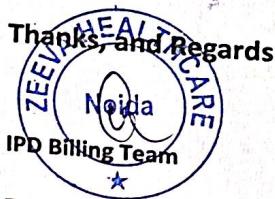
## TO WHOMSOEVER IT MAY CONCERN

The following is the breakup of the patient Procedure package (IVF) & package exclusions have been billed extra.

Patient Name: Mrs. Khusboo

UHID: UHID232402207

IVF Package Breakup	
Room Rent	3500.00
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Consultations	4800.00
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Ultrasound Charges	5000.00
OT Consumables	5101.00
Diet charges	1000.00
<b>Total</b>	<b>111000.00</b>



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.HA 103A, First Floor, Sector 104, Noida-201304. J-65, Patel Nagar 1, Ghaziabad, Uttar Pradesh - 201001



**Break up of the Consumables for the Patient Mrs. Khushboo,  
UHID232402207**

S.No.	Description	Quantity	Rate	Amount
1	Adult Under PAD	2	130	260
2	Betadine Solution 100ml	1	104	104
3	D/S (40*40) Sheet	3	45	135
4	D/S Needle no.16	1	6	6
5	D/S Syringes 10cc	3	10	30
6	D/S Syringes 20cc	1	11	11
7	D/S Syringes 2cc	3	9	27
8	D/S Syringes 5cc	2	10	20
9	Gauze 7*7	5	52	260
10	I Gel	1	700	700
11	IC Cannula 22G	1	12	12
12	In.Pantop	1	258	258
13	Inj.Atropine	1	5	5
14	Inj.Emset	1	13	13
15	Inj.Fentanyl	1	56	56
16	Inj.Glycopyrolate	1	13	13
17	Inj.Mozolam	1	33	33
18	Inj.PCM 100ml	1	317	317
19	Inj.Propofol	1	162	162
20	Inj.Sufacef	1	418	418
21	Inj.Termin	1	57	57
22	Sevoflurane	1	600	600
23	IV Set	1	162	162
24	Justin Supp.	1	20	20
25	Lox 2% Jelly	1	35	35
26	NS 500ml	1	35	35
27	OT Apron	3	45	135
28	OxySet	1	225	225
29	RL 500ml	2	57	114
30	Ryles Tube	1	11	11
31	Sterile Gloves 6.5	2	31	62
32	Sterile Gloves 7.0	3	41	123
33	Sterile Water 100ml	5	3	15
34	Suction Catheter	1	76	76
35	Tegaderm 1623	1	94	94
36	Gamjee Roll	2	65	130
37	Prolene	1	188	188
38	TUR Set	1	179	179
			<b>Total</b>	<b>5101</b>





H-1A/37, Sector 63, Noida, Gautam Buddha Nagar, U.P.  
Contact : 8377855100, 9310186506 Email: info@zeeva.in  
Website: www.zeeva.in

## Cash Transfer Receipt



<b>Receipt No</b>	: TKM242500774	<b>Date</b>	: 30-Oct-2024 11:02 AM
<b>UHID</b>	: UHID232402207	<b>IPID</b>	: NIP242501709
<b>Patient Name</b>	: Khushboo	<b>Sex/Age</b>	: Female/30 Years
<b>Doctor</b>	: DR SHWETA GOSWAMI	<b>Company</b>	: SELF
<b>Payment Mode</b>	: Transfer		

**Net Amount:** ₹ 90000.00/-

**Rupees In Words :** Rupees Ninety Thousand Only



**Print Date :** 08-Nov-2024 05:27 PM



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://unit1.zeevahis.in/MPatient/ptCashReceipt.aspx?6221



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HA 103A, First Floor, Sector 104, Noida-201304. J-65, Patel Nagar 1, Ghaziabad, Uttar Pradesh - 201001



**Breakup of the Lab Consumables for the Patient-Mrs.Khushboo,  
UHID232402207**

S.no.	Name of the Consumables	Amount
1	Flushing Media	3249
2	Fertilizing Media	2230
3	Culture Oil	711
4	Culture Media	2720
5	Hyase	659
6	PVP	489
7	Density Gradient Media	797
8	Thawing Media	1862
9	Screening Dish	447
10	Centrewell Dish	360
11	Fouwell Dish	184
12	ICSI Dish	52.5
13	14 ML Tube	218
14	5 ML Tube	150
15	15 ML Tube	101
16	Transfer Pipette	742
17	Semen Container	216
18	Dedudation Pipette	675
19	ET Catheter	2987
20	ICSI Needle	3200
21	ART Tips	49.5
22	OPU Needle	2000
	<b>Total</b>	<b>24099</b>





H-1A/37, Sector 63, Noida, Gautam Buddha Nagar, U.P.  
 Contact : 8377855100, 9310186506 Email: info@zeeva.in  
 Website: www.zeeva.in

## DETAIL BILL



<b>Bill No</b>	: ANCTCS242501837	<b>Bill Date</b>	: 30-Oct-2024 03:00 PM
<b>UHID</b>	: UHID232402207	<b>ID</b>	: NIP242501709
<b>Doctor</b>	: DR SHWETA GOSWAMI	<b>Ward/Unit/Bed</b>	: DELUXE/103
<b>Company</b>	: SELF	<b>DOD</b>	: 30-Oct-2024 03:00 PM
<b>DOA</b>	: 30-Oct-2024 09:30 AM	<b>Guardian Name</b>	:
<b>Patient Name</b>	: Khushboo	<b>Age/Sex</b>	:
<b>Address</b>	: Greater Noida ,Noida,Uttar Pradesh,INDIA		
<b>Marital Status</b>	: Married		

Sr No	Date	Code	Service Name	Doctor	Rate	Qty	Net Charge
1	<b>CONSULTATION</b> 30-Oct-2024	SR0602	PAC	DR SHWETA GOSWAMI	1000.00	1	1000
2	<b>Package</b> 30-Oct-2024		IVF Package		100000.00	1	100000



PrintDate: 08-Nov-2024 05:27 PM

<b>Hospital Charge</b>	101000.00
<b>Pharmacy Charge</b>	
<b>Hospital Discount</b>	11,000.00
<b>Net Charge</b>	90,000.00
<b>Received Amount</b>	90,000.00
<b>Refund Amount</b>	0.00
<b>Due On Bill</b>	0.00



## DETAIL BILL

<b>BILL No</b>	: ANCICS242501837	<b>Bill Date</b>	: 31-Oct-2024 03:00 PM
<b>UHID</b>	: UHID232402207	<b>ID</b>	: NIP242501709
<b>Doctor</b>	: DR SHWETA GOSWAMI	<b>Ward/Unit/Bed</b>	: DELUXE/103
<b>Company</b>	: SELF	<b>DOD</b>	: 31-Oct-2024 03:00 PM
<b>DOA</b>	: 30-Oct-2024 09:30 AM	<b>Guardian Name</b>	:
<b>Patient Name</b>	: Khushboo	<b>Age/Sex</b>	: 30/Female
<b>Address</b>	: Greater Noida ,Noida,Uttar Pradesh,INDIA		
<b>Marital Status</b>	: Married		

Sr No	Date	Code	Service Name	Doctor	Rate	Qty	Net Charge
1	CONSULTATION 30-Oct-2024	SR0602	PAC	DR SHWETA GOSWAMI	1000.00	1	1000
2	Package 30-Oct-2024		IVF Package		100000.00	1	100000
					<b>Total:</b>		<b>100000.00</b>
					<b>Total:</b>		<b>100000.00</b>



PrintDate: 09-Nov-2024 10:55 AM

Hospital Charge	101000.00
Pharmacy Charge	
Hospital Discount	11,000.00
Net Charge	90,000.00
Received Amount	90,000.00
Refund Amount	0.00
Due On Bill	0.00



Registration No:RMEE2122600

Application No:MEE0171473



Department of Medical Health & Family Welfare  
Goverment of Uttar Pradesh

RENEWAL OF MEDICAL ESTABLISHMENT CERTIFICATE

OFFICE OF THE CHIEF MEDICAL OFFICER, Gautam Buddha Nagar

Certificate No: CMEE2497628

Issuance Date: 17/05/2024

This is to certify that the medical establishment having Name ZEEVA HEALTH PLUS, Type MEDICAL CLINIC, Address H-1A/37, SECTOR -63, NOIDA, U.P., GAUTAM BUDDHA NAGAR, UTTAR PRADESH - 201301 is operated by PRIVATE LTD.(ZEEVA HEALTH PLUS PVT LTD) for providing InPatient(No. of bed-2)/Outpatient medical facilities MEDICINE,ONCOLOGY,GYNECOLOGY,INFERTILITY.The medical establishment is registered with us for the period 17/05/2024 To 30/04/2025.The Medical establishment will be operated by the in-charge of the medical establishment according to the terms/details mentioned below as given in the application form.

1. Owner/Partner Details:-

S.No.	Name	Father Name	Mobile No.	Age	Address
1	VIKAS GOSWAMI	R P GOSWAMI	9717018050	40	D-158, SECTOR 27, NOIDA, GAUTAM BUDDHA NAGAR, UTTAR PRADESH - 201301

2. Person Incharge Details:-

2.1 Name: SHWETA GOSWAMI

2.2 Mobile No.: 9315918149

2.3 Qualification: MBBS MD FNB

2.4 Registration No.: 91008

2.5 Address: D-158, SECTOR 27, NOIDA, GAUTAM BUDDHA NAGAR, UTTAR PRADESH - 201301

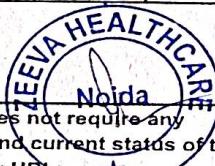
3. Doctor Details:-

S.No.	Name	Qualification	Institution	Registration Type/No.	Job Type
1	DR SHWETA GOSWAMI	MBBS MD FNB	MULANA AZAD MEDICAL COLLEGE	SMC / 91008	PART TIME
2	DR VIKAS GOSWAMI	MBBD MD DNB	RAJIV GANDHI CANCER INSTITITE	SMC / 72610	PART TIME

4. Paramedical staff Details:-

S.No.	Name	Qualification	Institution	Registration Type/No.	Job Type
1	PRIYA	OT TECHNICIAN	TECH MAHINDRA SMART ACADEMY FOR HEALTHCARE DELHI	NA / TM0890DOJL19	PART TIME
2	JYOTI	ANM	MAHESHWARI NURSING OF PARAMEDICAL INSTITUTE ALIGARH	NA / 43841	PART TIME

This is a computer generated certificate. It does not require any signature. To verify the authenticity, validity and current status of the certificate, please check through the following URL:- <http://localhost:6411/Public/ClericalNUH>



Chief Medical Officer  
Gautam Buddha Nagar  
गौतम बुद्ध नगर (उपनगर)  
Uttar Pradesh

Note: At the time of future inspection, if it is found that the In-charge of establishment as mentioned in the application form does not operate the institution or violate the rules or if any other type of irregularity found in the working, then the registration of the institution can be cancelled without notice.