

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	c) Type of Hospital:	Network : <input type="checkbox"/>	Non Network : <input checked="" type="checkbox"/>	(if non network fill section E)
a) Hospital ID:					
c) Name of the treating doctor:	GOSWAMI PREDHATI SHWEETA NAME MIDDLE NAME				
e) Qualification:	MBBS, MS (Obs & Gynae) FNB				g) Phone No. 9560801635
f) Registration No. with State Code:	UPMC 91008				i) Registration No. with State Code: UPMC 91008

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:	SURNAME KHUSHBOOMI MIDDLE NAME				
b) IP Registration Number:			c) Gender: Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>	d) Age: Years Y Y Months M M	e) Date of birth: 30 05 93
f) Date of Admission:	20 NO 24	g) Time: H H M M	h) Date of Discharge: 20 11 24	i) Time: H H M 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: D D M M Y Y	m) Gravida Status: <input type="checkbox"/> <input type="checkbox"/>	
l) 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 11100			

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description
i. Primary Diagnosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Primary Infertility
ii. Additional Diagnosis:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
iii. Co-morbidities:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
iv. Co-morbidities:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
b)	ICD 10 PCS	Description
i. Procedure 1:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
ii. Procedure 2:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
iii. Procedure 3:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
IV. Details of Procedure:	Ovum pick up	

c) Pre-authorization obtained:	<input type="checkbox"/> Yes <input type="checkbox"/> No	d) Pre-authorization Number:	<input type="checkbox"/>	
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="checkbox"/>	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	Noida Sector 63				
City:	Gautam Buddha Nagar	State:	Uttar Pradesh		
Pin Code:	201301	b) Phone No.	9560801635	c) Registration No. with State Code:	ATTACHED
d) Hospital PAN:	AABFZ6B8IN	e) Number of Inpatient beds	002	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:	<input type="text"/>				

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: 08 11 24

Place: Noida Sector 63

Signature and Seal of the Hospital Authority:

DR. SHWEETA GOSWAMI

MBBS, MS (Obs & Gynae) FNB

UPMC REGISTRATION No.-91008

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

Date: 08th 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
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
Total	111000.00



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: 08th 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
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
Total	111000.00



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



+91 83778 55100

info@zeeva.in
www.zeevafertility.com

.H1A/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



**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
			Total	5101



+91 83778 55100



info@zeeva.in
www.zeevafertility.com



.H1A/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



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



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

Net Amount: ₹ 90000.00/-

Rupees In Words : Rupees Ninety Thousand Only



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



+91 83778 55100
://unit1.zeevahis.in/HPatient/ptCashReceipt.aspx?6221



Info@zeeva.in

www.zeevafertility.com



.H1A/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



**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
	Total	24099

