VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR

DATE : 13-Apr-2022

WITHOUT PREJUDICE
SHORTFALL LETTER

CLAIM No.: DEL-0422-CL-0003707

To

Ms. MOHUYA BANERJEE
NA,
DELHI,Delhi-0
Phone No: 9563011118
Email ID: MOHUYA.BANERJEE@HCL.COM

Agent Code:
Dev Officer Code:

Dear Madam,

Sub: **Claim Number:** DEL-0422-CL-0003707 , **Policy Number:** 124500/48/2022/3115 , **Corporate Name:** HCL TECHNOLOGIES LIMITED , **Policy Holder:** MOHUYA BANERJEE , **Employee ID:** 51898957 , **Patient Name:** CHHANDA BANDOPADHYAY , **Card Number:** DEL-OI-H0351-001-0173073-C , **Hospital Name:** HEALTH WORLD HOSPITALS (A UNIT OF PARASHMANI MEDICAL CENTRE PVT LTD) , **Hospital IP Number:** 5291 , **DOA:** 27-Mar-2022 , **Ailment:** CHRONIC RHINOSINUSITIS

We acknowledge receipt of claim documents in the above connection.

On a scrutiny of the papers received we notice that we require the following documents to proceed further:

1. Req HCL claim form

We shall be able to proceed further with the matter only on your submission of the above requirements along with copy of this letter.

You can submit the soft copy of the document at 'claimsdocuments@vidalhealthtpa.com' and send the hard copy within 15 days to the below mentioned address.

We seek your compliance as above within 7 days from the date of this letter.

Assuring you our best services at all times.

Thanking you,

Yours faithfully,

Authorized Signatory

Note: This is a system generated letter does not require signature.

HCL Technologies Ltd

HOSPITALIZATION TREATMENT CLAIM SUMMARY FORM

EMPLOYEE DETAILS		MEDICAL CYCLE: 2021-22		
Claim No. : 734739	**No. of Claim Entries :** 1	**Total Claim :** 35068.00	**Status :** Submitted	
Name : Mohuya Banerjee		**EmpCode :** 51898957		**DOJ :** 30 Oct 2020
Email ID : MOHUYA.BANERJEE@HCL.COM		**Landline/Mobile :** 9563011118		**PayRollAreaCode :** BG
Payee Name : Mohuya Banerjee		**Bank Name :** HDFC BANK		
IFSC Code : HDFC0000015		**Account No. :** 50100310479169		

PATIENT'S DETAILS		
Name : CHHANDA BANDOPADHYAY	**Relation with the Employee :** mother	**Age :** 49

CLAIM DETAILS	
Name of Hospital : HealthWorld Hospitals	
Date of admission : 3/27/2022	**Date of Discharge :** 3/30/2022

#	Description	Amount	Claimed(Y/N)	Remarks
1	Room Charges for Patient	0.00		
2	Room Charges for Attendant/Guests	0.00		
3	Test(s) /X-Charges	26,070.00		
4	Medicine Expenses	1,848.00		
5	Doctor's Fee	1,150.00		
6	Operation Theater Charges	0.00		
7	Surgery Charges	0.00		
8	Nursing Charges	0.00		
9	Any Other Charges(give brief details)	6,000.00		
	Total Claim Amount	35,068.00		

This is to confirm that the below given items as checked are being provided from my end and they are genuine and correct as per my understanding.

Original Discharge summary	☑
Discharge Summary should include	☑
It should be on the Hospital Letter Head	☑
The letter head should bear hospital address, telephone nos., email id, fax nos. etc	☑
Name of the patient, Age, Gender	☑
Referred from/By	☐
IP No	☑
Date & time of Admission & Date & time of discharge	☑
Name of the treating doctor / s	☑

Final Diagnosis	
Provisional Diagnosis	☑
Chief Complaints/Presenting complaints	☐
Past History of Presenting illness with duration	☐
History of any other ailment, treatment, consultation etc. with Personal History	☐
Menstrual History in case of female patients	☐
General Physical Examination, Vitals	☐
Systemic Examination	☑
Investigations done at the hospital and elsewhere and Findings	☐
Treatment given in detail	☑
Surgery Details with Date of Surgery, Procedure, Type of Anaesthesia, Name of the Surgeon, Asst Surgeon, Anaesthetist, Procedure Notes	☑
Course in the hospital	☐
Condition at Discharge	☑
Discharge Advice and Medications	☑
Follow-up Instructions	☐
Signed by the Surgeon/Medical Superintendent/ Doctor who treated the patient	☐
In case of maternity, details of Gravida (GPAL – Gravida / Para / Abortion / Living children) to be given	☐
Original Medicine Bills	☑
Original Reports/ Tests	☑
Original Bills of reports/ Tests	☑
Break up details for hospitalization Final bill	☐
Pre numbered cash paid receipt for Hospitalization Payment	☐
Signed Discharge Voucher	☐
Signed Print out of the Claim Form	☐
Staple all the supports carefully to ensure there is no loss in transit	☑

CLAIM HISTORY

Date	Status	Name	Remarks
01-Apr-2022	Submitted	Mohuya Banerjee	All relevant proofs are with me but there is not option for uploading the proofs in the portal. This cost is for the pre and post surgery.

Declaration

I hereby agree, affirm and declare that:

1. The statements/information given/stated by me/us in this claim form are true, correct and complete.
2. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
3. If I have given/made any false or fraudulent statement /information /Documents, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past,present or future. Further, I am aware that submission of fraudulent claims can lead to disciplinary action under the Company policies up to and including termination.
4. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
5. I have read and understood the indicative list of Over the Counter Drugs.
6. Non Medical items are not payable under the policy.
7. I have read and understood that treatment for Cosmetic/Acne /Alopecia (Hair fall treatment)/ Malasma /hypo pigmentation / Infertility & Contraception related treatment/ HIV related Problem / Congenital External diseases is not payable.

Please note that before dropping the claim, you have to enter claim information in the medical

register which is kept on the medical claim drop box.

Place: DURGAPUR, WEST BENGAL
Date: Apr 01, 2022

Mohuya Banerjee
Signature of Insured Employee

Important:
Since it is a pre-requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the Insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the same on the Bill-cum-Receipt issued by them.

AUTHORISATION LETTER TO VIDAL HEALTH TPA PVT. LTD.,

To

The Medical Superintendent
VIDAL HEALTH TPA PVT. LTD.

Sub: Request to verify /obtain copies of the Medical Records

I have undergone treatment for---CHHANDA BANDOPADHYAY---
From---27-Mar-2022--- to---30-Mar-2022--- in your hospital / Clinic under

I consent & authorize my insurer (Oriental Insurance Company) and it TPA Vidal Health TPA Pvt Ltd., to seek necessary medical information from the hospital / Medical Practitioner with regards to the settlement of this Medical claims.

Pls. provide the necessary help and inputs required for the same information/records required by the insurance. I have no objection whatsoever in this regard.

Thanking you,

Signature of the Patient: Chhanda Bandopadhyay
Name of Patient: CHHANDA BANDOPADHYAY

Signature of the Employee: Mohuya Banerjee
Name of Employee: MOHUYA BANERJEE

Place: DURGAPUR, WEST BENGAL

Date: 02/April/2022