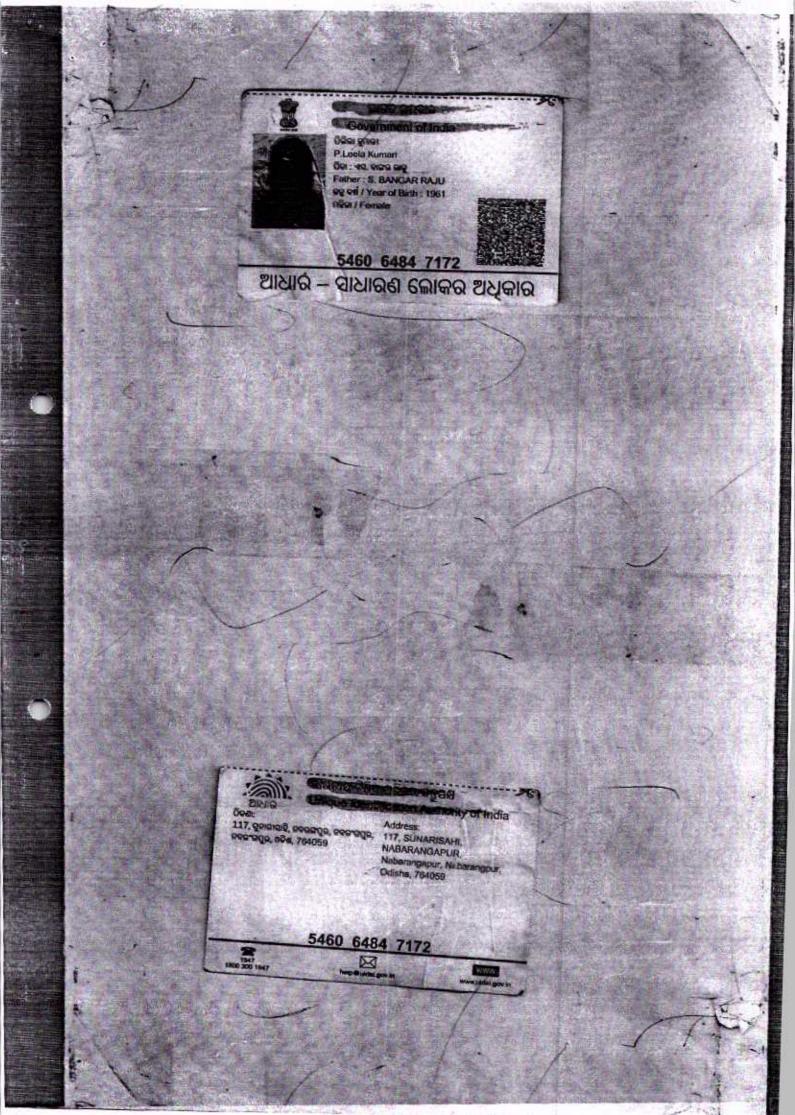
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Medi Assist	REQUEST FOR CASHLESS	HOSPITALISATION FOR	R MEDICAL INSURAN	CE POLICY	
Name of the Hospital Hospital Location   R   Hospital Fax No.   O   DE TAILS OF THIRD PA	AMN AGAR VISA	ALAM PATINIA	99 J	Heselaille	
	Medi Assist Insurance TPA Pyt Ltd	b) Tollfree PhoneNumber:	1800 425 9449	(To be	1800 425 9559
	Principal Communication of the	o Be filled in By Insured / Pa	tient		
a) Name of the Patient: b) Gender:	Massign	AUDMA			onooni
e) Consact number:	8280041400	Monda W M	diDirectainth 2	THE RESERVE AND ADDRESS OF THE PARTY OF THE	61
g) Policynumber/Name of 2	ALL THE PROPERTY OF THE PARTY O	I TO THE A A	10 Number 4019		2+
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k) Contact number, if any:		I I EN BO THE THE MAIN DAMES	(PLEASE COMPLETE DECLA	R ATION ON THE REVERS	SE SIDE OF THIS FORM
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e) Duration of the present of	iment: Day Di Duta of first consultat a	est Nou 4 day	it. Pent history of	my decrea	ud sleep.
f) Provisional diagnosis:		TABLE ANGINE	present		
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Ji If other treatments provide details:		- AdHow	did Injuryoccur:	· LUUUI	
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() In case of accident: v. injury/Disease caused duete	Lis it HTA: Yes M6 6. Date of injury.  substance share / alcohol consumption: Yes	WW VI Fest conducted to	iii.Reported to Police		M FIR No.
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Details of the patient admitted at Detectardmission.	F2 72 17 arm	12 19	Mandatory. Past History of any chronic@hvis		(Month/year)
d) is this an emergency (a plant	ned hospitalization event Emergency	Plenned	Diabetes	- I JELL BYES	M M V V
di Expected no. of days stay in h		Sharing A/c	☐ Heart Disease		
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specify). Other hospital expent II All includive package charges.			Any other Ailment give		
mil Sum Rotal expected cost of h	ospitalization Rs.	62000			
			_ L	(PLEASE READ	VERY CAREFULLY)
We confirm having read unders	tood and agreed to the Declaration on the reverse of this	DECLARATION DECLARATION			
a) Name of the treating doctor	Dr. G. LAVIT	VnAPIstoria	namenaruru	TENNING.	Territoria de la composición dela composición de la composición de la composición dela composición dela composición dela composición dela composición de la composición de la composición dela composición
b) Qualification:	0.00 GRegistration No. with State	eCode:		JOE BUSEL	KALE
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Dr. (	- /- K	Patient/InsuredName 8 IMPORTANT, PLEASET	NOTE THAT IS NOT THE PARTY OF T	fin	
	Regd. No. 50031		C		
OMNI	Consultari Gardiologist RK Super Special Osp	ital			
(A Unit	of INCOR Hospital (P) Visakhapatnam-4	Ltd.)			





# THE NEW INDIA ASSURANCE CO. LTD.

Wholly owned by Government of India

# Insurance Cashless e-Card

Employee Name:	P Mukesh	Policy Holder:	Tata Consultancy Services Ltd
Employee ID:	1296311	Policy Number:	920000/34/17/04/00000001
Policy Start Date:	01-Apr-2017	Policy End Date:	31-Mar-2018
Room Eligibility:	Twin sharing At	Croom	

Beneficiary name	Medi Assist ID	DOB	Relation
P Mukesh	4019244210	04-Oct-1995	Self
P Leeta Kumari	4019635672	24-Jan-1962	Mother

#### **HELPLINE NUMBERS:**

#### 24 hrs toll-free no.:1800 208 1033

- This card is only for identification and is not an authorization to proceed with the treatment or a guarantee for payment.
- In the case of photoless identity cards issued to beneficiaries, acceptable proof of identity such as Aadhar Card/Passport/Driver License/ Ration Card / Voters ID Card / PAN Card should be presented at hospitals.
- This non-transferable identification card is valid at selected Network Hospitals & will enable Card Holder to avail cashless hospitalization only on the basis of preauthorization by Medi Assist.
- For the latest updated hospital list, login to www.mediassistindia.com.

For Cashless Pre-Authorization request/queries please write to <u>cashless@mediassistindia.com</u>.

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#### MEDI ASSIST INSURANCE TPA PRIVATE LIMITED.

Tower D, 4th Floor, IBC Knowledge Park, 4/1 Bannerghatta Road, Bhavani Nagar, Bengaluru, Karnataka 560029. CIN: U85199KA1999PTC025676 Website: <a href="https://www.mediassistindia.com">www.mediassistindia.com</a>

OMNI	RK"
O : 12 41	Manager
Super Speciality	Hospital

Name P. Leela bunasil Agel Sex S. Wt.

INITIAL ASSESSMENT

(TO BE FILLED BY DOCTORS)

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associated of sweathing .

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yesterday

(85/60)

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Name P. Leele Kumai AgeS64Sexf Wt MR.N&Q3851P.No.23622

## DOCTOR'S ORDERS

Date/Time	PROGRESS NOTE	DOCTOR'S ORDERS
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	GRBS - 415 mg/dl.	12 UNITS - 12 UNITS -
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	St. CREATININE	F TAB. AZTOR, 80 MG, 1 STAT.
	Sr. ELECTROLYTES	(5) TAB . ECOSPRIN, 325 NG, ISTAT
ĵ.	SCREENING.	(6) NTG - 2.5 ML ) HOUR.
	2D EC10-	9 02 INHALATION -
		( GRBS TID
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Name D. leale tour	Age Cha Sex F Wt
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MR.No. 800 IP.No. 23822

## DOCTOR'S ORDERS

Date/Time	PROGRESS NOTE	DOCTOR'S ORDERS
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	Medi Assist Insurance TPA	A Pyt Ltd   NTollEres   Dome Numb	1800 425 9449	(To be Filled in block	
		To Be filled in By Insured /		d TallFree FAX Number: 1800 425	9559
al Name of the Patient:	Marchar	THE COLUMN TWO COLUMN	Henenan		
b) Gender.	Male Ufemale	chape years ( Months to sa	di Deterof birth	D (800 (DECTA)	
e) Contect number.	82800414	55 nimured	ard ID Number 7019	4 0 1 1961	mn.
gi Policynumber/Name of con	porate: TATA	OWS DITA	The sale as the last	hiEmployeests 1 1 9 4 7	1111
	other MediclainvHealthinsurance:	Yes Na CompanyName			
Give details:	L				
Do you have a family physics     Contact number if any:		me of the family physician	00300001		00
	made Dull	TO BE FILLED BY THE TREATING DOC	(PLEASE COMPLETE DEGL) TOR / HOSPI TAL	AR ATION ON THE REVERSE SIDE OF THIS	FORM)
a) Name of the treating doctor	A TOTAL	JUM ARD	b)Contact No.	089130803	00
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	the Contains on	in chest since 4 day	the sucating atal		0 / .
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() Provisional diagnosis:		UNSTABLE ANGII	V a allmontany:		
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It if Surgical name of surgery:	The same of	68/c BO, 2mg Fruma	Mixtrad , ly	. NT G 1 amp 45 mg	lho
	"procedure "(	Ah"	I.ICD topics	Code:	m <del>d</del>
ji if other treatmentsprovide details:		101	low did injury occur.		ŦŦ
f) in case of accident:	Li H. RTA: TT Yes ( T ME ii Dar	Politica I V I			
	ta H. RTA: Yes MG ii. Dat substance abuse / alcohol consumption:	group of the last training the same	I N. Reported to Police I to establish that	Ves No in FIR No.	
mit in case of Maternity: 5 Details of the partent admitted	- L	A []	the second secon	Delivery/LMP: [0] [0] [M] [M] [V]	171
Dateofadmission:	12 12 17	to time 12 29	Mandetory: Past History of any dyronicillar		
C is this an emergency/a planner	d hospitalization evant	ency Planned	E Diabetes		[Y]
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at expectant that invostigation	+ diagnostics	20000	Deteoarthettu	M M V	
NICU Charges (@3, 000)	CAh' package charge	6000	Authma/COPD / Bro		
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it wil increasesbraceds completely	hyspanism of Con	" STOOD	+ 1	octore.	7
m) Sum Total expected cost of hor	spitalization	67000			
		DECLARATION		IPLEASE READ VERY CAREFULLY	
We confirm having read understo	od and agreed to the Declaration on the re	eversa of this form			
al Name of the treating doctor:	Or GRAV	I KUMAR		MUNICIPALITY	
b) Ovalification:	0 m	No. with ScateCode:			
Hospital Seal (Must include Hospital				No.	1
	RAVINUMAR.	MD., DM. MEGETANT: PLEA			
	Regd No. 50031				-
	Consultark Cardiolog	ospital			
OMNI I	RK Super Special I INCOR Hospital	(P) Ltd.)			
TAL OTHER	Visakhapatnam-4	4			



Name p. leala bemarie	AgeStyl.Sex.fWt
	MR.No.\$0355P.No.23822

### MEDICATION CHART

		TO BE FILLED BY DO	осто	2			TO	BE	FILLE	D BY	NUR	SE
S.	Date/						Sig.		Sig.		Sig.	
	Time	NAME OF THE DRUG	Dose	Route	Freq	Sig.	Time	With Name	Time	With Name	Time	With Name
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