REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY
PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: Cloudnine Hospital - Malleshwaram
Hospital location: MALLESHWARAM, BENGALURU
Hospital ID:
Hospital email ID:
ROHINI ID:

DETAILS OF THIRD PARTY ADMINISTRATOR

a) Name of TPA company: Medi Assist Insurance TPA Pvt Ltd
b) Phone no.: 080 22068666
c) Toll Free Fax no.: 1800 425 9559

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient: anupama gopalan
b) Gender: ☐ Male ☑ Female ☐ Third gender
c) Contact no.: 8088568149
d) Alternate contact no.:
e) Age: Years 29 Months 06
f) Date of birth: 21071993
g) Insurer ID card no.: 401882750
h) Policy number/Name of corporate:
i) Employee ID:
j) Currently do you have any other medical claim/health Insurance: ☐ Yes ☐ No
j.1) Insurer name:
j.2) Give details:
k) Do you have a family physician, if yes: Name:
k.1) Contact no.:
L) Occupation of insured patient:
m) Address of insured patient:

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor: DR SRIPRADA
b) Contact no.:
c) Name of Illness/disease with presenting complaints: LSCS
d) Relevant clinical findings:
e) Duration of the present ailment: ☐ days
e.1) Date of first consultation: D D M M Y Y Y Y
e.2) Past history of present ailment if any:
f) Provisional diagnosis: G2 P1+1 38+1 Weeks Term LSCS - Negative
f.1) ICD 10 code:
g) Proposed line of treatment: ☐ Medical management ☑ Surgical management ☐ Intensive care ☐ Investigation ☐ Non-Allopathic treatment
h) If investigation and/or medical management, provide details:
h.1) Route of drug administration: ☐ IV ☐ Oral ☐ Other
i) If Surgical, name of surgery: LSCS
i.1) ICD 10 PCS code:
j) If other treatments provide details:
k) How did injury occur:
L) In case of accident: i. Is it RTA: ☐ Yes ☐ No ii. Date of injury: D D M M Y Y Y Y iii. Reported to Police: ☐ Yes ☐ No iv. FIR no.:
v. Injury/Disease caused due to substance abuse/alcohol consumption: ☐ Yes ☐ No vi. Test conducted to establish this, If yes attach reports: ☐ Yes ☐ No
m) In case of maternity: G P L A n) Expected date of delivery: D D M M Y Y Y Y

DETAILS OF THE PATIENT ADMITED

a) Date of admission: 13022023
b) Time of admission: H H M M
c) This is ☐ an emergency/ ☐ a planned hospitalization event
d) Expected no. of days stay in hospital: 4 Days
e) Days in ICU: ☐ Days
f) Room type: Single Private Room

Medi Assist

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PART C (Revised)

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g) Per Day Room Rent + Nursing & Service charges + Patient's Diet: Rs.

h) Expected cost for investigation + diagnostics: Rs.

i) ICU Charges: Rs.

j) OT Charges: Rs.

k) Professional fees Surgeon + Anesthetist fees + Consultation charges: Rs.

L) Medicines + Consumables cost of Implants: (specify if applicable) Rs.

m) Other hospital expenses if any: Rs.

n) All inclusive package charges if any applicable : Rs.

o) Sum Total expected cost of hospitalization Rs. 85000

p. Mandatory past history of any chronic illness. If yes (since month/year)

- ☐ 1. Diabetes (M M Y Y)
- ☐ 2. Heart Disease (M M Y Y)
- ☐ 3. Hypertension (M M Y Y)
- ☐ 4. Hyperlipidemias (M M Y Y)
- ☐ 5. Osteoarthritis (M M Y Y)
- ☐ 6. Asthma/ COPD / Bronchitis (M M Y Y)
- ☐ 7. Cancer (M M Y Y)
- ☐ 8. Alcohol or drug abuse (M M Y Y)
- ☐ 9. Any HIV or STD / related ailments (M M Y Y)
- 10. Any other ailment give details:

DECLARATION (PLEASE READ VERY CAREFULLY)

We confirm having read understood and agreed to the declaration of this form

a) Name of the treating doctor: DR SRIPRADA

b) Qualification:

c) Registration No. with State code:

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA not governed by the terms and conditions of the policy will be paid by me.
d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / TPA
e. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/ TPA.
h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim"

a) Patient's / Insured's name:

b) Contact number: 8088568149 c) Email ID: (Optional)

d) Patient's / Insured's signature:

Date: 13022023 Time: 1418

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA/ Insurance Company within 7 days of the patient's discharge.
c. We agree that TPA / Insurance Company will not be Liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
f. We will abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/ considered in package).
h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws.

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, Supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of Operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

Hospital seal:

KIDS CLINIC INDIA LIMITED
No. 47,17th Cross, 11th Main,
Malleshwaram,
Bengaluru - 560 055.

Doctor's signature:

Date: 13022023 Time: 1418

GIPSA NETWORK-DECLARATION FORM
(To be filled by the Hospitals)

Name of the Hospital: Cloudnine Hospital - Malleshwaram Date of Admission 13/02/2023.

Address: MALLESHWARAM, BENGALURU

PATIENT NAME/INSURED NAME (BLOCK LETTERS): anupama gopalan AGE/SEX 29/06 Female

(To be filled by the Insured/policy holder/Attendant)

1. *Do you have an Insurance policy?* *YES/NO*

If yes, then please select: New India/ United India/ National Insurance/ Oriental Insurance/others

*Policy No*_____
TPA Name Medi Assist Insurance TPA Private Limited
TPA card No: 4018827750

2. *Have you contacted TPA or Insurance Company for cashless facility?* *YES/NO*

3) Whether patient opted for Eligible Room Category under Policy: *YES/NO*

If No, then kindly mention the opted room category: Single Private Room

On my own option, I wish to avail above facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed tariff for the treatment. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed tariff for the treatment and balance amount will be borne by me / patient only.

I have also been explained that when room service of a category other than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me/ patient only

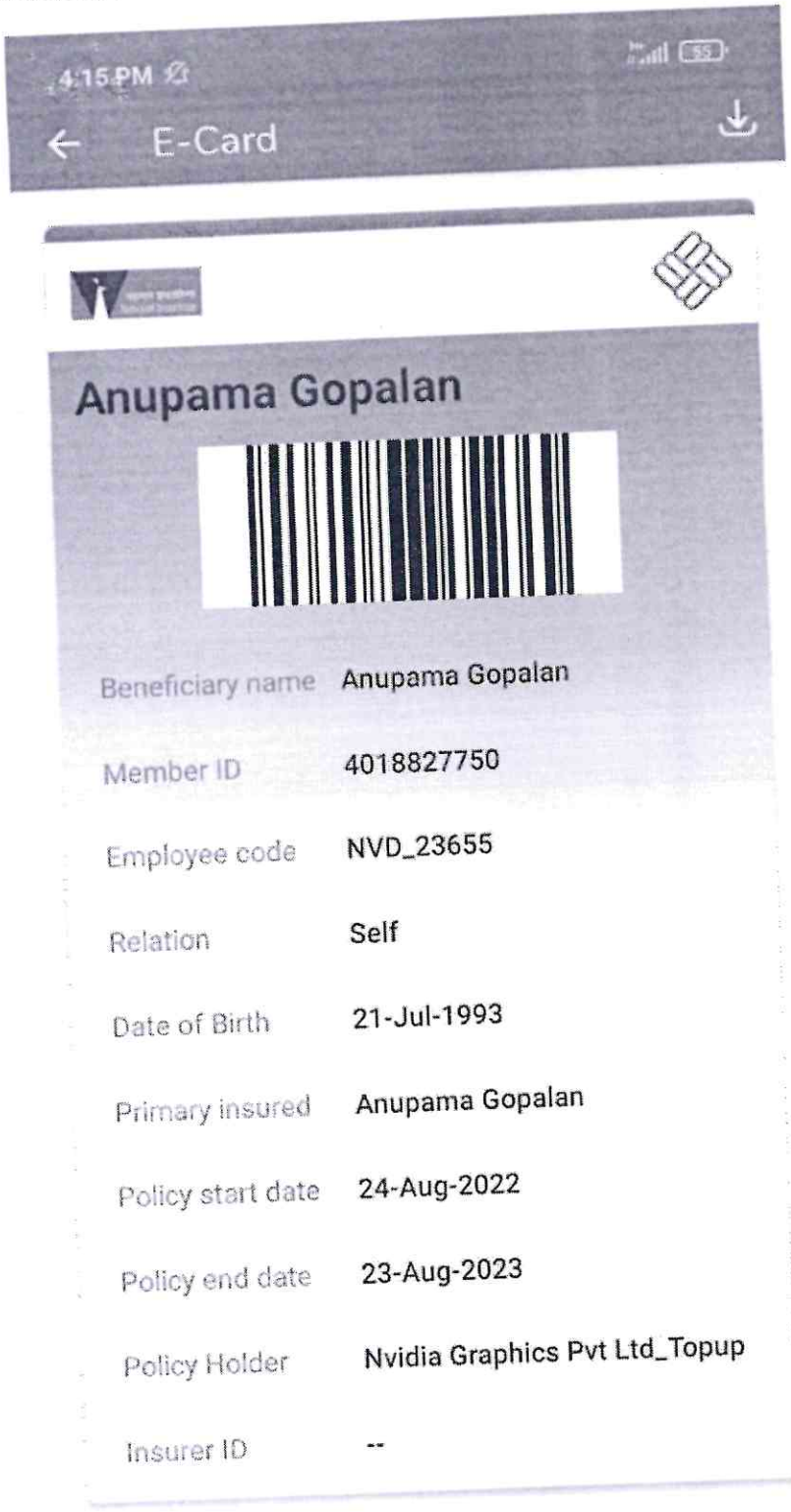
Anupama

Signature: anupama gopalan
Name of the Patient/Patient's attendant:

Mobile No 8088568149
E –Mail.....
PAN / Form 60: .....
Aadhar Card Number.....

Signature:.....
Name of the Hospital Representative &Hospital Seal:

KIDS CLINIC INDIA LIMITED
No. 47, 8th Cross, 11th Main,
Malleshwaram
Bengaluru - 560 055.


4:15 PM
E-Card
Anupama Gopalan
Beneficiary name Anupama Gopalan
Member ID 4018827750
Employee code NVD_23655
Relation Self
Date of Birth 21-Jul-1993
Primary insured Anupama Gopalan
Policy start date 24-Aug-2022
Policy end date 23-Aug-2023
Policy Holder Nvidia Graphics Pvt Ltd_Topup
Insurer ID --

आयकर विभाग
Income Tax Department

PAN VERIFICATION RECORD

Permanent Account Number

BBGPG5868L

Name	ANUPAMA GOPALAN
Gender	FEMALE
DOB	21/07/1993
Verified On	19/01/2023 14:23:20

Digitally Signed On:
19/01/2023 14:23:20 IST

Note:

1. This PAN data is verified by DigiLocker (https://digilocker.gov.in) as per data provided by the issuing authority, Income Tax Department, Govt. of India.
2. This digitally signed verification document is valid as per the IT Act 2000 when used electronically.

भारत सरकार
GOVERNMENT OF INDIA

AADHAAR

Anupama Gopalan

1993-07-21

Female

xxxxxxxx4122

Address:

D/O: Ramaswamy Gopalan No 36/1 3rd Main Road Vyalikaval Bangalore North - Bangalore - Karnataka 560003

Verified by DigiLocker

Tap to Zoom

आधार -आम आदमी का अधिकार

cloudnine

ULTRASOUND REPORT

Patient name	Mrs. ANUPAMA	**Age/Sex**	29 Years / Female
Patient ID	100651683	**Visit no**	6
Referred by	Dr. Sriprada Vinekar	**Visit date**	27/01/2023
LMP date	22/05/2022, LMP EDD: 26/02/2023[35W 5D]		

OB - 2/3 Trimester Scan Report

Real time B-mode ultrasonography of gravid uterus done.

Route: Transabdominal

Single intrauterine gestation

POG BY LMP 35 WEEKS 5 DAYS
PRIOR ANOMALY SCAN DONE HERE, NO OBVIOUS ANOMALIES
CURRENT INDICATION - INTERVAL GROWTH SCAN

Maternal

Internal os closed

Fetus

Survey

Presentation - Cephalic

Placenta - Posterior

Lower margin of placenta is well above the internal os.

Liquor - Adequate

Amniotic fluid index = 15.6

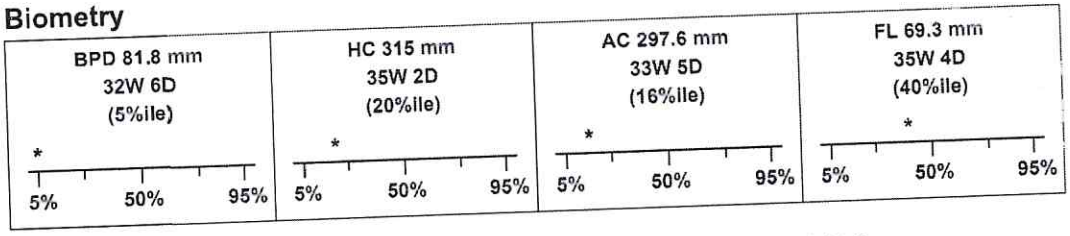
Umbilical cord - Normal

Fetal activity present

Cardiac activity regular

Fetal heart rate - 151 bpm

Biometry



Estimated fetal weight according to BPD,HC,AC,FL :- 2406 + / - 240.6 gms.

Fetal Anatomy

Fetal cranium, thorax, diaphragm, abdomen, KUB to the extent seen normal.
Please note this is not an anomaly scan, rest of the fetal anatomy could not be adequately evaluated due to advanced gestational age and fetal position.

Fetal doppler

Middle Cerebral Artery PI - 1.44

Umbilical Artery PI - 0.68

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Patient name	Mrs. ANUPAMA	Age/Sex	29 Years / Female
Patient ID	100651683	Visit no	6
Referred by	Dr. Sriprada Vinekar	Visit date	27/01/2023
LMP date	22/05/2022, LMP EDD: 26/02/2023[35W 5D]		

Cerebroplacental ratio - 2.118

Biophysical profile:8/8

Fetal movements-2/2;Fetal Respiratory movements-2/2

Fetal tone- 2/2 ;Amniotic fluid- 2/2.

Impression

Single intrauterine gestation corresponding to a gestational age of 34 Weeks 3 Days assigned as per biometry (BPD,HC,AC,FL)

Menstrual age 35 Weeks 5 Days

* Placenta - Posterior
* Presentation - Cephalic
* Liquor - Adequate (AFI - 15.6)
* BPP - 8/8, Good
* Fetal AC is at 16th centile. EFW is at 26th centile
* Estimated fetal weight : 2406 +/- 240.6 gms.
* Normal umbilical and MCA doppler study

Please note - Assessment of fetal anomalies depends on fetal position, liquor volume and period of gestation at the time of scan, all anomalies cannot excluded by ultrasonography. This is not an Anomaly scan.

Declaration - I declare that while conducting ultrasonography I have neither detected nor disclosed the sex of her foetus to anybody in any manner.

Dr. NIKITHA N
Consultant Radiologist.
Fellow in Feto-Maternal Medicine
KMC No: 114270

For reference only. Consult your Obstetrician. This is digital report, hence signature of sonologist is not required. Please consult your Obstetrician for details.

ಭಾರತ ಸರ್ಕಾರ
Government of India

ಭಾರತೀಯ ವಿಶಿಷ್ಟ ಗುರುತು ಪ್ರಾಧಿಕಾರ
Unique Identification Authority of India

ನೋಂದಣಿ ಸಂಖ್ಯೆ/ Enrolment No.: 2086/10127/03234

To
ಅನುಪಮ ಗೋಪಾಲನ್
Anupama Gopalan
D/O: Ramaswamy Gopalan
No 36/1
3rd Main Road
Vyalikaval
Bangalore North
Bangalore Karnataka - 560003
9480072612

Signature Valid

ನಿಮ್ಮ ಆಧಾರ್ ಸಂಖ್ಯೆ / Your Aadhaar No. :
7789 9690 4122
VID : 9144 7426 8275 8870

ನನ್ನ ಆಧಾರ್, ನನ್ನ ಗುರುತು

Government of India

ಅನುಪಮ ಗೋಪಾಲನ್
Anupama Gopalan
ಜನ್ಮ ದಿನಾಂಕ/DOB: 21/07/1993
ಸ್ತ್ರೀ/FEMALE

Issue Date: 16/11/2016

7789 9690 4122
VID : 9144 7426 8275 8870

ನನ್ನ ಆಧಾರ್, ನನ್ನ ಗುರುತು

Government of India

AADHAAR

ಮಾಹಿತಿ

- ಆಧಾರ್ ಗುರುತಿನ ಪುರಾವೆಯೇ ಹೊರತು ಪೌರತ್ವದಲ್ಲ
- ಸುರಕ್ಷಿತ ಕ್ಯೂಆರ್ ಕೋಡ್/ಆಫ್ಲೈನ್ XML/ಆನ್ಲೈನ್ ದೃಢೀಕರಣ ಬಳಸಿ ಗುರುತನ್ನು ಪರಿಶೀಲಿಸಿ
- ಎಲೆಕ್ಟ್ರಾನಿಕ್ ಪ್ರಕ್ರಿಯೆ ಮೂಲಕ ಮುದ್ರಿತವಾದ ವಿದ್ಯುನ್ಮಾನ ದಾಖಲೆ ಇದಾಗಿದೆ

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- Verify identity using Secure QR Code/ Offline XML/ Online Authentication.
- This is electronically generated letter.

- ಆಧಾರ್ ದೇಶದಾದ್ಯಂತ ಮಾನ್ಯತೆಯನ್ನು ಪಡೆದಿದೆ
- ಸುಲಭವಾಗಿ ಸರ್ಕಾರಿ ಹಾಗೂ ಸರ್ಕಾರೇತರ ಸೇವೆಗಳನ್ನು ಪಡೆಯಲು ಆಧಾರ್ ಸಹಾಯವಾಗಲಿದೆ.
- ನಿಮ್ಮ ಮೊಬೈಲ್ ಸಂಖ್ಯೆ ಮತ್ತು ಇ-ಮೇಲ್ ಐಡಿ ಅನ್ನು ಆಧಾರ್ ನಲ್ಲಿ ನವೀಕರಿಸಿದಿ
- ಆಧಾರ್ ನ್ನು ನಿಮ್ಮ ಸ್ಮಾರ್ಟ್ ಫೋನ್ ನಲ್ಲಿ ಕೊಂಡೊಯ್ಯಿರಿ- mAadhaar ಅಪ್ಲಿಕೇಶನ್ ಬಳಸಿ

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Unique Identification Authority of India

ವಿಳಾಸ:
ತಂದೆ / ತಾಯಿಯ ಹೆಸರು: ರಾಮಸ್ವಾಮಿ ಗೋಪಾಲನ್,
ನಂ 36/1, 3ನೇ ಮೇನ್ ರೋಡ್, ವ್ಯಾಲಿಕಾವಲ್,
ಬೆಂಗಳೂರು ಉತ್ತರ, ಬೆಂಗಳೂರು,
ಕರ್ನಾಟಕ - 560003

Address:
D/O: Ramaswamy Gopalan, No 36/1, 3rd Main Road, Vyalikaval, Bangalore North, Bangalore,
Karnataka - 560003

Download Date: 14/01/2022

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