

# Cashless Authorisation Letter

Authorisation is Valid for Admission from      03/10/2024      To      10/10/2024



Claim Number : MDI8907762

Date : 05/10/2024

To,  
The Medical Director,  
Mgm New Bombay Hospital  
Plot No.35, Sector 3, Near Vashi Police Station Vashi

**IC Name :** The Oriental Insurance Company Ltd  
**Name of TPA :** MDIndia Health Insurance Pvt. Ltd.  
**Proposer Name :** Air India Limited  
**Patient's Member :** Lalita Ravindra Lokhande  
**MD ID No :** MDIS-0037797965  
**Relation with Propose :** Mother

**Phone :** 022-27822203  
**Fax :** 27820520

**Rohini ID :** 8900080114708

**EMP No :** 80036921

**EMP Name :** Makrand Ravindra Lokhande

Dear Sir/Madam,  
This has reference to the Pre-Authorization request submitted on 04/10/2024 , We hereby authorize Cashless facility as per details mentioned below:

Patient Name : Lalita Ravindra Lokhande	Age : 67	Gender : Female
Policy Number : 580000/48/25/00726	Expected Date of Admission : 03/10/2024	
Policy Period : 01/04/2024 To 31/03/2025	Expected Date of Discharge : 05/10/2024	
Room Category : SINGLE  Eligible Room Category as per T&C of Policy Contract :  Room is payable upto : 7500 Per day	Estimated Length of Stay : 3	
Provisional Diagnosis : AFI	Proposed Line of Treatment : Conservative	

#### **Authorization Details :**

Date & Time	Reference Number	Amount	Status
04/10/2024 5:47:05PM	MDI8907762	32,000	INITIAL AL
05/10/2024 9:41:10PM	MDI8907762	24,526	FINAL AUTHORISATION

Total Authorized Amount:- Rs. Fifty Six Thousand Five Hundred Twenty Six Only.

#### **Authorisation Remarks :**

HOSPITAL DISCOUNT :- 10% will be applicable on the final bill excluding ppn packages (discount shall be applicable on medicine and implant excluding NPPA implants and DPCO drugs)

Please don't collect the hospital discount amount from patient / insured. As per the norms set by the regulator, the network hospital is suppose to mention the discount amount on the final hospital bill.

Please note that GIPSA PPN Network - Declaration Form duly filed and signed by the patient or patient attender, along with Authorized signatory and hospital seal is mandatory and should be attached in the Claim file.

#### **Hospital Agreed Tariff :**

##### **I) Package Case :**

Agreed Package Rate :

0

##### **II) Non Package Case :**

- |                                  |   |   |
|----------------------------------|---|---|
| i) Room Rent/day                 | : | 0 |
| ii) ICU Rent/day                 | : | 0 |
| iii) Nursing Charges/Day         | : | 0 |
| iv) Consultant Visit Charges/Day | : | 0 |
| v) Surgeon's fee/OT/Anaesthetist | : | 0 |
| vi) Others (specify)             | : | 0 |

#### **Authorization Summary :**

Total Bill Amount :	72,795 (INR)
Other Deductions :	8,989 (INR)
Discount :	7,280 (INR)
Co-Pay :	0 (INR)