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by Joint Commission International

Service Tax #				
GSTIN : 36AAACA5443N3ZH		In Patient Bill	- Bill of Supply	Reference No :
Bill To(1) : United India Insurance Co. Ltd		Age: 71Yr 3Mth 26Days	UHID : APJ1.0001607472	
Name : Mr. SAINATH REDDY D		Sex: Male		
Father Name : PANDU RANGA REDDY				
Address : LAXMI NAGARAM VILLAGE VELDURTHY MANDAL : Kurnool Andhra Pradesh India, Cell No:91-9676268190		IP Number: IP436335 		
Pan Number :				
Doctor Name : DR. SRINIVAS S		Bill No : JBH-ICR-240538		
Speciality : PODIATRIC		Date : 12-Sep-2023 Time : 18:24:37		
Ward Name : 3rd FloorSpecial Ward				
Bed No : 313 (Private)				
Billing Type : CREDIT Authorization No: 34361412		Admission Date : 09-Sep-2023 07:20:35 am		
TPA/Corporate(1): MEDI ASSIST INSURANCE TPA PVT LTD		Discharge Date : 12-Sep-2023 16:27:03 pm		
Employer Name : TECH MAHINDRA				
SL. No	Service	Gross Amount	Discount	Net Amount(R)
1	Assistant Doctor Fee(999311)	4500.00	0.00	4500.00
2	Assistant Surgeon Fee(999311)	4800.00	0.00	4800.00
3	Blood Administration Charges(999311)	6200.00	3,100.00	3100.00
4	Consultation(999311)	10000.00	0.00	10000.00
5	Invasive Procedures(999311)	13180.00	0.00	13180.00
6	Investigations(999311)	8270.00	827.00	7443.00
7	Medical Administration(999311)	1410.00	0.00	1410.00
8	Non Invasive Procedure(999311)	6980.00	0.00	6980.00
9	Nutritional and Functional Assessment Charges(999311)	2000.00	0.00	2000.00
10	OT Charges(999311)	17050.00	0.00	17050.00
11	OT Consumables(999311)	2754.00	0.00	2754.00
12	OT Pharmacy(999311)	5865.80	0.00	5865.80
13	Professional Charges(999311)	30000.00	0.00	30000.00
14	Ward Consumables(999311)	410.00	0.00	410.00
15	Ward Pharmacy(999311)	25126.74	0.00	25126.74

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EMERGENCY CALL - 1066

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"



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Bill No : JBH-ICR-240538

Commissioner Accredited
by Joint Commission International

SL. No	Service	Gross Amount	Discount	Net Amount(R)
	Sub Total	138,546.54	3,927.00	134,619.54
Total Service Amount After Discount				134,619.54
Total Discount()				4,829.00
Service Amount After Discount (Bill of Supply)				129,791.00
Other Information :				
Bill of Supply	: JBH-ICR-240538			129,791.00
Tax Invoice :	: JBH-TCR-6709			35,721.00
Total Payable Amount				165,512.00
Authorization Amount(1)	MEDI ASSIST INSURANCE TPA PVT LTD			141,389.00
Deposit (23169235)	(Cash:0.00, NonCash:10,000.00)			10,000.00
To Pay	(Cash:0.00, NonCash:14,123.00)			24,123.00
Refunded ()				
Net Amount				141,389.00
Payment Details:				
Amount in words : ₹ One Hundred Forty-One Thousand Three Hundred Eighty-Nine Only				
No Tax is Payable on Reverse Charge Basis				
Payment Details: ₹. (23206698-CARD) Received with thanks sum of ₹. 14,123.00(CARD(BHIM)) ₹ Zero Only From Mr. SAINATH REDDY D				
<div style="text-align: center;">  Mr. Ch.Sreeram . Signature Of Patient/Attendant Generated By PAN NO:AAACA5443N * TAN NO:HYDA02318B * ROHINI ID:8900080328488 Online Payment access- https://pay.apollohospitals.com </div>				
Disclaimer : *All the above dates indicated as Date & Time of the entry only Page 2 of 19				

Name : Mr. SAINATH REDDY D	IP No : IP436335	Bill No : JBH-TCR-6709
GSTIN : 36AAACA5443N3ZH	Apollo Health City campus, Jubilee Hills, Hyderabad - 500 096. +91-1860 258 1066 apollohealthcity@apollohospitals.com www.apollohealthcity.com	
In Patient Bill Tax Invoice For appointments or online consultation, visit www.asksorche.com		Reference No : 
Name : Mr. SAINATH REDDY D Age: 7 Yr 3 Mth 26 days Sex: Male		UHID : APJ10001607472
Father Name : Father Name : PANDU RANGA REDDY Address : LAXMI NAGARAM VILLAGE VELDURTHY MANDAL Kurnool Andhra Pradesh India, Cell No:91-9676268190		 IP Number: IP436335 
Pan Number : Doctor Name : DR. SRINIVAS S Speciality : PODIATRIC Ward Name : 3rd FloorSpecial Ward Bed No : 313 (Private)		Bill No : JBH-TCR-6709 Date : 12-Sep-2023 Time : 18:24:37 
Billing Type : CREDIT Authorization No : 34361412 TPA/Corporate(1) : MEDI ASSIST INSURANCE TPA PVT LTD		Admission Date : 09-Sep-2023 07:20:35 am Discharge Date : 12-Sep-2023 16:27:03 pm
Employer Name: TECH MAHINDRA		
IRN NO		
SL. No	Service	Amount(₹)
1	Room Rent(999311)	34,020.00
Service Amount		34,020.00
Total Discount		0.00
After Discount		34,020.00
GST (Room Rent: 5.00%): CGST:(2.50%) 850.50 : SGST:(2.50%) 850.50		1,701.00
Total Bill Amount (Cash:, NonCash:14,123.00)		35,721.00
Net Amount		35,721.00
Payment Details: Interim bill amount in words : Rupees Thirty-Five Thousand Seven Hundred Twenty-One Only No Tax is Payable on Reverse Charge Basis		
Mr. Ch.Sreeram .		Mr. Ch.Sreeram .
Generated By		Cashier
Disclaimer : *All the above dates indicated as Date & Time of the entry only		
Page 1 of 2		

Regd. Office : Apollo Hospitals Enterprise Limited, No. 19, Bishop Garden, Raja Annamalaipuram, Chennai - 600 028, Tel: +91-44-28293333, Fax: +91-44-28290956
Corporate Identity Number (CIN) : L85110TN1979PLC008035

 EMERGENCY CALL - 1066

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IP BILL RECEIPT

Uhid : APJ1.0001607472	Patient Identifier : IP436335	Receipt No : 23206698
Patient Name : Mr. SAINATH REDDY D		Receipt Date : 12-Sep-2023 6:24:37 pm

Address : LAXMI NAGARAM VILLAGE
VELDURTHY MANDAL Kurnool
Andhra Pradesh India



Transaction Type : IP BILL

Transaction Amount : 14,123.00

Mode Of Payment	Instrument Number	Transaction Amount
BHIM(CARD)	9187	14,123.00

Cashier

Remarks:

NOTE: All Payments Including Dr.Fees Should be Paid at Billing Counter Only

Mr. Ch.Sreeram.



EMERGENCY CALL - 1066

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Uhid : APJ1.0001607472	Patient Identifier : IP436335	Receipt No : 23169235
Patient Name : Mr. SAINATH REDDY D		Receipt Date : 09-Sep-2023 7:22:27 am

Address : LAXMI NAGARAM VILLAGE
VELDURTHY MANDAL Kurnool
Andhra Pradesh India



Transaction Type : DEPOSIT

Transaction Amount : 10,000.00

Mode Of Payment	Instrument Number	Transaction Amount
BHIM(CARD)	9187	10,000.00

Received with Thanks ': 10,000.00

' Ten Thousand Only (INR) From Mr. SAINATH REDDY D

Cashier

Remarks:deposit

Mr. C Raju

NOTE: All Payments Including Dr.Fees Should be Paid at Billing Counter Only



EMERGENCY CALL - 1066



Medi Assist

Cashless Authorization Letter (34361412)
(Please quote this reference number in all future correspondence.)

E-card Claims Plan hospitalization Hospitals



XAP34361412

Date :12 Sep 2023

To

The Administrator / Medical Superintendent,
Apollo Hospitals,
Jubilee Hills,
Hospital ID: (50073)
Rohini Id: 8900080328488

Dear Partner,

With reference to your request (34361412) for final cashless pre-authorization, we hereby authorize INR 141389 against your final bill amount INR 170000. The details of the pre-authorization are as follows:

Patient Details

Patient Name	D. Sai Natha Reddy ✓
Relation to Primary Beneficiary	Father-in-Law
Age	71
Gender	M
Insurance Company	United India Insurance Co. Ltd. ✓
Medi Assist ID	5019047547
Policy Holder	Tech Mahindra LTD ✓
IP No.	0217002822P114036646_TOPUP
Policy No.	30 Mar 2023 to 29 Mar 2024
Policy Period	Reddygari Venkatarami Reddy
Primary Beneficiary	286199
Primary Beneficiary Employee ID:	UIIC230086913042861995
Insurer Claim No	
Insurer Member ID	

Treatment Details

Provisional Diagnosis	Type 2 diabetes mellitus with foot ulcer
Expected Date Of Admission	09 Sep 2023
Treating Doctor	Dr Srinivas Seshabhattaru
Procedure / Treatment Planned	Debridement of burn
Estimated Date of Discharge	12 Sep 2023
Room Category Occupied	Single private room
Length Of Stay	3
Eligible Room Category	Single Ward (Private / Special / Executive Ward)

Authorization Details

#	Status	Received Date	Cumulative Amount	Cumulative Authorized
1	Pre-Auth Processed	08 Sep 2023 20:09	150000	87750
2	Pre-Auth Processed	12 Sep 2023 16:09	170339	141389

Amount Rs 141389 (One Lakh Forty One Thousand Three Hundred and Eighty Nine).

www.santillan.com

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Hospital Agreed Tariff :

I. Package Case

Agreed Package Rate

NA

Package charges exclude cost towards implants/co-morbidity/extended stay

II. Non Package Case

Room Type	Room Rent	Nursing
NA	NA	NA

Consultation Visit Charges/ Surgeon's fee/ OT/ Anaesthetist : As per customary and reasonable charges

Authorization Summary

Total bill amount (INR)	170339
Other Deductions(INR)*	8413
Copay (INR)	15710
Hospital Discount (INR)	4827
Deductibles (INR)	0
Total Authorized Amount(INR)	141389
Amount to be paid by Insured (INR)	24123

***Deduction Details**

S.no	Description	Bill Amount (INR)	Deducted Amount (INR)	Admissible Amount (INR)	Deduction Reason
1.	associated room charges	660	660	0	Room stay not justified with submitted medical documents:-660.00 Non-justified to the Ailment : FLEXI OXYGEN MASK ADULT MAKE:ROMSON (PMIS01937023)-302.00,NME GLOVES ENCORE MICROOPTIC 6.5 ANSELL (PMIS01937023)-228.00,NME VASOFIX CANNULAE SIZE: 20G B.BRAUN (PMIS01937023)-232.00,Non-justified to the Ailment : VEIN-O-LINE 10CM STOPCOCK -ROMSONS (PMIS01937023)-347.00,Non-justified to the Ailment : DC UNDER PAD 60X90CM #(HSN:48189000) (PMIN0125719421)-99.00,NME SURGEN GOWN XL (REINFORCED)#(HSN:9018) (PMIN0125719421)-700.00,Non-justified to the Ailment : DC WET WIPES#(HSN:9619) (PMIS0125089615)-130.00,NME SENSIKARE NITRILE P/F EXAM GLOVES-L 100'S (MEDLINE) (PMIS0125089615)-200.00,Non-justified to the Ailment : VIGGO-1WAY EXTENSION INFUSION SET 15CM(HSN:9018) (PMIS0125089615)-365.00,Non-justified to the Ailment : DC WET WIPES#(HSN:9619) (PMIS0125095700)-130.00 NME ENLIVA NITRILE P/F GLOVES(M) 100S (PMIS0125095700)-400.00,Non-justified to the Ailment : GAMJEE PAD 30CM * 30CM(HSN 3005) (PMIS0125097825)-298.00,Non-justified to the Ailment : SANGOFIX ES (BLOOD SET) (HSN:90183990) (PMIS0125101541)-211.00,Non-justified to the Ailment : SANGOFIX ES (BLOOD SET) (HSN:90183990) (PMIS0125104147)-211.00
2.	ot consumables	9181	3763	5418	
3.	other miscellaneous charges	2000	2000	0	NME Nutritional and Functional Assessment:-2000.00
4.	blood charges	580	580	0	NME CROSMATCHING AND GROUPING (IBR823660)-290.00,NME CROSMATCHING AND GROUPING (IBR824007)-290.00
5.	documentation charges	1410	1410	0	NME Medical Records,-1410.00

Terms and conditions for authorization

1. Cashless authorization letter issued on the basis of information provided in pre-authorization form. In case of misrepresentation/concealment of facts, any material difference/deviation/ discrepancy in information is observed in discharge summary / IPD records then cashless authorization stand null & void. At any point of claim processing Insurer or TPA reserves right to raise queries for any other document to ascertain the admissibility of claim.
2. KYC (Know your customer) details of proposer/employee/beneficiary are mandatory for claim payout above Rs.1 lakh.
3. Network provider shall not collect any additional amount from the individual in excess of Agreed Package Rates except cost 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).
4. Network provider shall not make any recovery from the deposit amount collected from the insured except for the cost 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)
5. 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 or get the same refunded to the policy holder from the network provider and/or take necessary action as provided under the MOU
6. Where treatment/ procedure to be carried out by a Doctor/Surgeon of insured's choice (not empaneled with the Hospital) network provider may give treatment after obtaining specific consent of the policyholder.
7. Differential cost borne by the policyholder may be reimbursed by Insurer subject to terms and conditions of the policy.

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

1. Detailed discharge summary and all bills from the Hospital

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 A P O L L O H O S P I T A L S

b) Hospital ID

c) Type of Hospital Network Non Network: (if non network fill section E)

d) Name of the Treating Doctor D R . S R I N I V A S S

e) Qualification

f) Registration No. with State Code:

g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of The Patient M r . S A I N A T H D

b) IP Registration Number 1 P 4 3 6 3 3 5

c) Gender: Male Female

d) Age: Years: 7 1 Months M M

e) Date of birth: D D M M Y Y

f) Date of Admission 0 9 0 9 2 3

g) Time: 0 7 2 0

h) Date of Discharge 1 2 0 9 2 3

i) Time: 1 8 2 4

j) Type of Admission: Emergency Planned Day Care Maternity

k) If Maternity i) Date of Delivery D D M M Y Y

ii) Gravida Status: 1 4 1 3 8 9

l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased

m) Total claimed amount: 1 4 1 3 8 9

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a) ICD 10 codes Description

b) ICD 10 PCS

Description

i. Primary Diagnosis

i. Procedure 1:

ii. Additional Diagnosis

ii. Procedure 2:

iii. Co-morbidities

iii. Procedure 3:

iv. Co-morbidities

iv. Details of Procedure

c) Pre-authorization Obtained Yes No

d) Pre-authorization Number

e) If authorization by network hospital not obtained, given reason

f) Hospitalization due to injury Yes No

i. If yes give cause

Self-inflicted Road Traffic Accident Substance abuse/alcohol consumption ii) If injury due to substance abuse/ alcohol consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii) If Medico legal: Yes No iv) Reported to police Yes No

v) FIR No

vi) If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- Claim Form duly signed
- Original Pre-authorization approval letter
- Copy of the pre-authorization approval letter
- Copy of PhotoID Card of Patient Verified by hospital
- Hospital Discharge Summary
- Operation Theatre Notes
- Hospital main bill
- Hospital break-up bill
- Investigation reports
- CT/MR/USG/HPE investigation reports
- Doctor's reference slip for investigation
- ECG
- Pharmacy bills
- MLC reports & Police FIR
- Original death summary from hospital where applicable
- 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 A P O L L O H O S P I T A L S

J U B I L E E H I L L S

City: H Y D E R A B A D State: T E L U R U G A N A

Pin Code:

Phone No:

c) Registration No with State Code:

d) Hospital PAN: A A A C A S 4 4 3 N e) Number of inpatient beds to Police:

f) Facilities available in the hospital: i. OT Yes No ii. ICU Yes No

iii) Others:

DECLARATION BY THE HOSPITAL

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.

(PLEASE READ VERY CAREFULLY)

Sign & Seal of Hospital Authority:

Date: 1 3 0 9 2 3

Place: HYDERABAD





Authorization is valid for Admission up to 24 Sep 2023

(In case of non receipt of final bill & discharge summary within 7 days from discharge date, Authorization(s) issued for this hospitalization would be treated as void)



XAP34361412

Date :08 Sep 2023

To,

The Administrator / Medical Superintendent,
Apollo Hospitals,
Jubilee Hills,
Hospital ID: (50073)
Rohini Id: 8900080328488

Dear Partner,

With reference to your request (34361412) for cashless pre-authorization, we hereby authorize INR 87750 against an estimated cost of INR 150000. The details of the pre-authorization are as follows.

Patient Details

Patient Name	D Sai Natha Reddy
Relation to Primary Beneficiary	Father-in-law
Age	71
Gender	M
Insurance Company	United India Insurance Co. Ltd.
Medi Assist ID	5019047547
Policy Holder	Tech Mahindra LTD
IP No.	35.200.180.5
Policy No.	0217002822P114036646_TOPUP
Policy Period	30 Mar 2023 to 29 Mar 2024
Primary Beneficiary	Reddygari Venkatarami Reddy
Primary Beneficiary Employee ID	286199
Insurer Claim No	
Insurer Member ID	UIIC230086913042861995

Treatment Details

Provisional Diagnosis	Cutaneous abscess of right foot
Expected Date Of Admission	09 Sep 2023
Treating Doctor	Dr Srinivas Seshabhattaru
Procedure / Treatment Planned	Incision & Drainage
Estimated Date of Discharge	10 Sep 2023
Room Category Occupied	Single private room
Length Of Stay	1
Eligible Room Category	Single Ward (Private / Special / Executive Ward)

Authorization Details

#	Status	Received Date	Cumulative Amount	Cumulative Authorized
1	Pre-Auth Processed	08 Sep 2023 20:09	150000	87750

Total Authorized amount Rs 87750 (Eighty Seven Thousand Seven Hundred and Fifty).

Authorization Remarks :

INITIAL APPROVAL GIVEN FOR VALID ACTIVE LINE OF TREATMENT . FINAL APPROVAL WILL BE BASED ON DISCHARGE SUMMARY AND FINAL BILL

APR 2009 (60) 7472



REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

Name of the hospital:

APOLLO HOSPITALS

Hospital location:

JUBILEE HILLS HYDERABAD Hospital ID: 50073

Hospital email ID:

apollojohtpa.hyd@apolphospitals.com ROHINI ID: 8900080328488

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: SAI NATHA REDDY · P

b) Gender: Male Female Third gender

c) Contact no.: 9908229632

d) Alternate contact no.:

e) Age: Years 71 Months 03

f) Date of birth: 01/01/1938

g) Insurer ID card no.:

i) Employee ID:

h) Policy number/Name of corporate: TECH MAHINDRA

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: 4-G, Marigold Apartments, Andhra centre, Lingamalai Hyderabad - 500019.

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor: DR. SRINIVAS

b) Contact no. 9959885937

c) Name of illness/disease with presenting complaints:

d) Relevant clinical findings:

Right Foot Infection

- do -

e) Duration of the present ailment: 7 days

e.1) Date of first consultation: 02/09/2023

e.2) Past history of present ailment if any:

f) Provisional diagnosis:

Right Foot Infection with Abscess

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:

i.1) ICD 10 PCS code:

Abscess Drainage + Debridement.

j) If other treatments provide details:

k) How did injury occur:

Medical management

l) In case of accident: i. Is it RTA: Yes No ii. Date of injury: 01/09/2023 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: 01/09/2023

DETAILS OF THE PATIENT ADMITED

a) Date of admission: 09/09/2023

b) Time of admission: 10:00 AM

c) This is an emergency/ a planned hospitalization event

d) Expected no. of days stay in hospital:

02 Days

e) Days in ICU: Days

f) Room type: P+1, male

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REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

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

Rs. 8450/-

h) Expected cost for investigation + diagnostics:

Rs. 3000/-

i) ICU Charges:

Rs. 0/-

j) OT Charges:

Rs. 2500/-

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

Rs. 5000/-

l) Medicines + Consumables cost of Implants: (specify if applicable)

Rs. 5000/-

m) Other hospital expenses if any:

Rs. 0/-

n) All inclusive package charges if any applicable:

Rs. 150,000/-

o) Sum Total expected cost of hospitalization

Rs. 150,000/-

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

1. Diabetes

02 17

2. Heart Disease

05 17

3. Hypertension

05 17

4. Hyperlipidemias

05 17

5. Osteoarthritis

05 17

6. Asthma/ COPD / Bronchitis

05 17

7. Cancer

05 17

8. Alcohol or drug abuse

05 17

9. Any HIV or STD / related ailments

05 17

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-SRINIVAS
GENERAL SURGERY**

c) Registration No. with State code: **48542 TSMC**

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:

VENKATA RAMA BENDRA

b) Contact number:

7908 2296 37

c) Email ID: (Optional)

d) Patient's / Insured's signature:

Date:

Time:

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:



Doctor's signature:

Date:

Time:



United India Insurance Company Ltd.

Medical Records



- 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 / Voter 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 Network hospital list, login to www.mediassisttpa.in

Medi Assist Insurance TPA Pvt. Ltd.

Tower D, 4th Floor, IBC Knowledge Park, 411, Bannerghatta Road, K M Layout, Bengaluru,
Karnataka 560029.CIN: U85199KA1999PTC025676
Website: www.mediassisttpa.in Email: techm@mediassisttpa.in



Medi Assist



MA5019047547

Contact number: 08067615731 815-286-0999(Backup)





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

Name of the Hospital: APOLLO HOSPITALS Date of Admission: 9/9/2023

Address: JUBILEE HILLS, HYDERABAD

PATIENT NAME/INSURED NAME (BLOCK LETTERS): D.SALVATHA REDDY AGE/SEX 70 Y Male

(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. _____

TPA card No: _____

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:.....

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

Signature: D.Salvatha Reddy
Name of the Patient/Patient's attendant:

Signature: _____

Name of the Hospital Representative & Hospital Seal:



Mobile No. 9676268170

E-Mail: _____

PAN / Form 60: A.I.C.P.D.4950C

Aadhar Card Number: 549987963690



Venkata Reddy

Associate ID Board Group

286199

O+VE

Authorised Signature 10/07/19

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

Instructions:
 All fields marked with * are mandatory fields.
 B) Please fill the form in English and in BLOCK Letters
 C) Please read guidelines / detailed instructions overleaf
 D) List of two character ISO-3166 country codes are available overleaf

<input type="checkbox"/> PERSONAL DETAILS Name (Last name, First name, Middle name) Maiden Name (If any)* Father / Spouse Name* Mother Name* Date of Birth* Marital Status* Residential Status* Occupation* Tick if applicable : Residence for Tax purposes in jurisdiction(s) outside India	Application Type : <input type="checkbox"/> New <input type="checkbox"/> Update Account Type* : <input type="checkbox"/> Normal <input type="checkbox"/> Small KYC NUMBER :	
--	---	---

VENKATA RAMIREDDY REDDY GARI
R. C. MANDAVVA REDDY

ADDITIONAL DETAILS REQUIRED (If Applicant is resident outside India for Tax purposes)
 (Please read guidelines / details for Jurisdiction of Residence and Tax Identification Number)
 ISO - 3166 Country Code of Jurisdiction of Residence* : **IND**
 Tax Identification Number or equivalent (If issued by jurisdiction)* : **1234567890**
 Place / City of Birth* : **HYDROOL** ISO - 3166 Country Code of Birth* : **IND**

PROOF OF IDENTITY (PoI)
 PAN : **ATCPR1998B** UID (Aadhaar) : **12345678901234567890**
 Voter ID Card : NREGA Job Card : **12345678901234567890**
 Passport : **12345678901234567890** Passport Expiry Date : **DD-MM-YYYY**
 Driving License : Student : **12345678901234567890** Driving License Expiry Date : **DD-MM-YYYY**
 Others (any document notified by the central government) :

PROOF OF ADDRESS (PoA)
CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (One Certified Copy of any one of the following Proof of Address (PoA) needs to be submitted):
 Line 1* : **21-22, CHANDRABUDI (NIN), GADDIPET (Macherla)** City / Town / Village : **GADDIPET**
 Line 2 : **KURUMOOL (615A)** ISO - 3166 Country Code : **IND**
 Line 3 :
 State/U.T* : **AP** Pin / Post code : **500019** Aadhaar Card :
 Proof of Address* : Passport : Driving License : Others : Please Specify :
Correspondence / Local Address Details (In case the PoA is not the Actual address of residence where the applicant is currently residing. To be disclosed only and no PoA is required)
 Same as Current / Permanent / Overseas Address details : **4-6, MARIGOLD (Residential) B01 BUILDING** City / Town / Village : **LINGAMPALLA**
 Line 1* : **4-6, MARIGOLD (Residential) B01 BUILDING** ISO - 3166 Country Code : **IND**
 Line 2 :
 Line 3 :
 State/U.T* : **AP** Pin / Post code : **500019**

ADDRESS IN THE JURISDICTION DETAILS WHERE APPLICANT IS RESIDENT* (If Applicant is resident outside India for Tax purposes)
 Same as Current / Permanent / Overseas Address details Same as Correspondence / Local Address details
 Line 1* :
 Line 2 :
 Line 3 :
 State/U.T* : Pin / Post code : City / Town / Village :
 ISO - 3166 Country Code : **IND**

CONTACT DETAILS (One Certified Copy of any one of the following Proof of Identity (PoI) needs to be submitted):
 Tel. (Off) : **STD CODE** Tel. (Res) : **STD CODE** Mobile : **99887766554433221100**
 FAX : **STD CODE** Email ID : **VENKATAREDDY.GARI@HYDREDDY.COM**

DETAILS OF RELATED PERSON
 Addition of Related Person Deletion of Related Person KYC Number (If Available) : **12345678901234567890**
 Related Person Type: Guardian Of Minor Nominee Assignee Authorized Representative Beneficial Owner Beneficiary
 Name* : Prefix **Mr.** Firstname **VENKATA** Middle Name **RAMIREDDY** Last Name **GARI**

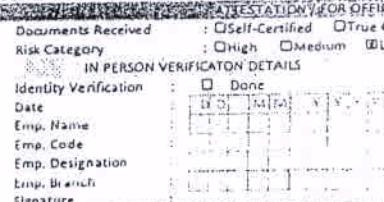
PROOF OF IDENTITY (PoI) (Mandatory if KYC number is not available. One Certified Copy of any one of the following Proof of Identity (PoI) needs to be submitted):
 PAN : **ATCPR1998B** UID (Aadhaar) : **12345678901234567890**
 Voter ID Card : NREGA Job Card : **12345678901234567890**
 Passport : **12345678901234567890** Passport Expiry Date : **DD-MM-YYYY**
 Driving License : Student : **12345678901234567890** Driving License Expiry Date : **DD-MM-YYYY**
 Others (any document notified by the central government) :

OTHER DETAILS
 Income Range : Below 1 Lac 5 Lac to 10 Lac 10 Lac to 15 Lac 15 Lac to 25 Lac 25 Lac and above
 Net Worth (In INR) : **1000000** As on : **DD-MM-YYYY**
 Educational Qualification : Below SSC DSSC HSC Graduate Masters Professional (CA, CS, CMA, Others)
 Please Tick If Applicable : Politically Exposed Person Related to Politically Exposed Person
 Any Other Information :

APPLICANT DECLARATION
 I hereby declare that the details furnished above are true and correct to the best of my/our knowledge and belief and I undertake to inform you of any changes therein, immediately, in case any of the above information is found to be false or untrue or misleading or misrepresenting, I am/we are aware that I/we may be held liable for it.
 I would like to share my personal / KYC details with Central KYC Registry.

TESTIMONY FOR OFFICER USE ONLY

Documents Received : Self-Certified True Copies Notary
 Risk Category : High Medium Low

IN PERSON VERIFICATION DETAILS	INSTITUTION DETAILS
Identity Verification : <input type="checkbox"/> Done	Name : Dr. S. M. A. M. A.
Date : 01-01-2018	Code : 1234567890
Emp. Name : S. M. A. M. A.	Stamp : 
Emp. Code : 1234567890	
Emp. Designation : Manager	
Emp. Branch : Hyderabad	
Signature : 	

Enrolment Stamp : **Enrolment Stamp**

Signature / thumb impression of Applicant : **VENKATA RAMIREDDY GARI**
 Place : **HYDERABAD**
 Date : **01-01-2018**

Apollo Hospitals Enterprise Limited
Hyderabad



ADMISSION NOTE

ADMISSION NOTE



NAME OF THE PATIENT

Sainath Reddy AGE 71 SEX M DATE 6/9/23

ADDRESS

PROVISIONAL DIAGNOSIS Rf. great toe gangrene - post debridement frequent discharge

Patient First Program Yes No

Patient has been informed about-

1. Nature of disease
2. Investigation treatment that the patient may need to undergo.
3. Probable duration of hospital stay
4. Probable cost of treatment
5. Probable outcome for the patient
6. Possibility that any of the above may change during the course of treatment and hospitalization.

SIGNATURE OF CONSULTANT

Dr. S. Srinivas

FOR OFFICE USE ONLY

PATIENT REPORTED AT

ADMITTED TO

CASH/CREDIT

IN CASE OF CREDIT

NAME OF CREDIT ORGANIZATION

AUTHORIZATION FROM

IN CASE OF CASH

ADVANCE PAID

PATIENT SHIFTED TO ROOM

ADMISSION ORDERS

INVESTIGATIONS

TREATMENT

(Stop) T-Clopirab Fcospri
Rest Continue same
medications as
before

SPECIAL INSTRUCTIONS

PRE-OP INSTRUCTIONS
(IN CASE OF SURGICAL CASE)

- Suspected Communicable disease
- Need for Tracheostomy care
- Need for Pressure ulcer care
- Needs Supplemental O2
- Need for NIV (CPAP, BIPAP)
- Others _____

9/9/23

POSTED FOR

NIL BY MOUTH

INFORM OT

PART PREPARATION

IV FLUIDS

PAC by Dr. Sanath Reddy

PATIENT ADVISED ADMISSION ON 23/9/23 7:30 AM / PM

PATIENT NEEDS TO REPORT TO ADMISSION COUNTER

PLEASE PRESENT THIS PAPER AT THE ADMISSION COUNTER

IN CASE YOU HAVE ANY PROBLEM PLEASE SEEK HELP FROM DOCTOR IN EMERGENCY ROOM

IF YOU HAVE BEEN ADVISED DAY CARE SURGERY, PLEASE COLLECT DAY CARE INSTRUCTIONS CARD FROM DOCTOR'S SECRETARY



Name : Mr. SAINATH REDDY D IP No : 1P436625@apollo.com

Payer Payable

SL. No	Service Code	Service Name (Order No.)	Alias Code	Dr Name	Start Date	End Date	Qty/Duration (in mins)	Reference Dis (%)	Amount(₹) Tariff
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Assistant Doctor Fee(999311)

Medical

1	8410	ASSISTANT DOCTOR FEE				4	4,500.00	0	4,500.00
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Dept Sub Total : 4,500.00
Dept Total : 4,500.00

Assistant Surgeon Fee(999311)

Medical

1	9303	ASSISTANT SURGEON FEE				1	4,800.00	0	4,800.00
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Dept Sub Total : 4,800.00
Dept Total : 4,800.00

Blood Administration Charges(999311)

Medical

1	1060058	Blood Administration Charges				2	3,100.00	0	3,100.00
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Dept Sub Total : 3,100.00
Dept Total : 3,100.00

Consultation(999311)

Consultation

1	2117	IP Visit Charges	Dr. SANJAY MAITRA (NEPHROLOG Y)		3	7,500.00	0	7,500.00
2	2117	IP Visit Charges	DR. SRINIVAS S (PODIATRIC)		1	2,500.00	0	2,500.00
Dept Sub Total :							10,000.00	

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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EMERGENCY CALL - 1066

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"



Invasive Procedures(999311)

Dialysis						Dept Sub Total :	13,180.00
						Dept Total :	13,180.00
1	5470	BICARBONATE DIALYSIS(ACUTE) (6881450)		1	6,590.00	0	6,590.00
2	5470	BICARBONATE DIALYSIS(ACUTE) (6886373)		1	6,590.00	0	6,590.00

Investigations(999311)

BioChemistry						
1	274	GLYCOSYLATED HEMOGLOBIN (HbA1C) WHOLE BLOOD (9836058)		1	1,910.00	-10 1,719.00
2	8774	GRBS (GRBS RANDOM BLOOD SUGAR)		1	330.00	-10 297.00
3	8774	GRBS (GRBS RANDOM BLOOD SUGAR)		1	330.00	-10 297.00
4	8774	GRBS (GRBS RANDOM BLOOD SUGAR)		1	330.00	-10 297.00
5	8774	GRBS (GRBS RANDOM BLOOD SUGAR)		1	330.00	-10 297.00
6	8774	GRBS (GRBS RANDOM BLOOD SUGAR)		1	330.00	-10 297.00
7	8774	GRBS (GRBS RANDOM BLOOD SUGAR)		1	330.00	-10 297.00
8	8774	GRBS (GRBS RANDOM BLOOD SUGAR)		1	330.00	-10 297.00

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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Regd. Office : Apollo Hospitals Enterprise Limited, No. 19, Bishop Garden, Raja Annamalaipuram, Chennai - 600 028, Tel: +91-44-28293333, Fax: +91-44-28290956
Corporate Identity Number (CIN) : L85110TN1979PLC008035



 EMERGENCY CALL - 1066

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"

Name : Mr. SAINATH REDDY For appointments or online consultation, visit R436635 kapollo.com

Bill No : JBH-ICR-240538

Organisation Internationale
de la Santé 330

297.00

Medical Administration(999311)

Medical Records

Dept Sub Total : 1,410.00
Dept Total : 1,410.00

Non Invasive Procedure(999311)

Blood Bank - 1 Products

1	6140	LEUCODEPLETED PACKED RED CELLS (Incl. LR Filter, NAT, Donor Antibody Screening, Buffy bag Charges) (IBR824007)	1	3,200.00	/	0	3,200.00
2	956	CROSSMATCHING AND GROUPING (IBR823660)	1	290.00	4		290.00
3	6140	LEUCODEPLETED PACKED RED CELLS (Incl. LR Filter, NAT, Donor Antibody Screening, Buffy bag Charges) (IBR823660)	1	3,200.00	/	0	3,200.00
4	956	CROSSMATCHING AND GROUPING (IBR824007)	1	290.00	4		290.00

Disclaimer : *All the above dates indicated as Date & Time of the entry only

Page 5 of 19

Regd. Office : Apollo Hospitals Enterprise Limited, No. 19, Bishop Garden, Raja Annamalaiapuram, Chennai - 600 028, Tel: +91-44-28293333, Fax: +91-44-28290956
Corporate Identity Number (CIN) : L85110TN1979PLC008035



 EMERGENCY CALL - 1066

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"



Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.apollo.com

Bill No : JBR-HCR-241538

Department Sub Total : 6,980.00
Dept Total : 6,980.00

Nutritional and Functional Assessment Char

		Nursing		4	2,000.00	0	2,000.00			
1	5742	Nutritional and Functional Assessment								
							Dept Sub Total : 2,000.00			
							Dept Total : 2,000.00			

OT Charges(999311)

09-Sep-2023

General Surgery

1	2103	Operation Theatre Charges (1524471)	09/09/2023 9:00	09/09/2023 9:30	0hr 29min	12,600.00	0	12,600.00
Dept Sub Total : 12,600.00								

Recovery Room

1	8875	RECOVERY ROOM CHARGES (1524471)	09/09/2023 9:40	09/09/2023 10:40	1hr 0min	4,450.00	0	4,450.00
Dept Sub Total : 4,450.00								
Dept Total : 17,050.00								

OT Consumables(999311)

General OT

1	027747000002 691784	GAMJEE ROLL - 15CMX2MT WITH ROLLER BANDAGE 15CMX3MT - 2 NOS. - READY TO STERILE - DOUBLE PACKING IN STERILISATION FLAT REEL WITH	2774700 0000269 1784	1	272.00	0	272.00
2	027747000002 691784	GAMJEE ROLL - 15CMX2MT WITH ROLLER BANDAGE 15CMX3MT - 2 NOS. - READY TO STERILE - DOUBLE PACKING IN STERILISATION FLAT REEL WITH	2774700 0000269 1784	1	272.00	0	272.00
3	010862000001 19735	PLAIN SHEET LARGE 120X210CM YVR (PMIS01937023)	1086200 0000119 735	1	250.00	0	250.00
4	027747000002 652092	VEIN-O-LINE 10CM STOPCOCK -ROMSONS (PMIS01937023)	2774700 0000265 2092	1	347.00	0	347.00

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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Bill No : JBTMCR 240538

Organisation Accredited by Joint Commission International

Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.apollo.com

5	027747000005	GLOVES ENCORE MICROOPTIC 6.5 - 6189 ANSELL (PMIS01937023)	2774700 0000561 89	2	228.00	0	228.00
6	027747000002	LAP SPONGE - WITH 60% 691785 MULTIFILAMENT X-RAY THREAD WOVEN IN - WITH WHITE LOOP READY TO STERILE - DOUBLE PACKING IN	2774700 0000269 1785	1	374.00	0	374.00
7	010821000001	FLEXI OXYGEN MASK ADULT 03108 MAKE:ROMSON (PMIS01937023)	1082100 0000103 108	1	302.00	0	302.00
8	027747000004	SYRINGES 10CC B.D 2319 (PMIS01937023)	2774700 0000423 19	2	68.00	0	68.00
9	027747000004	SYRINGES 5CC B.D 2318 (PMIS01937023)	2774700 0000423 18	2	36.00	0	36.00
10	027747000004	SYRINGES 2CC B.D 1943 (PMIS01937023)	2774700 0000419 43	2	28.00	0	28.00
11	027747000002	IV SET -ROMSON WITH NEEDLE 08128 (PMIS01937023)	2774700 0000208 128	1	153.00	0	153.00
12	027747000004	VASOFIX CANNULAE, SIZE: 20G - 2857 B.BRAUN (PMIS01937023)	2774700 0000428 57	1	232.00	0	232.00
13	027747000002	GAUZE SWABS - PLAIN - READY TO 690144 STERILE - DOUBLE PACCKING IN STERILISATION FLAT REEL WITH STERILISATION INDICATOR ON BOTH	2774700 0000269 0144	3	192.00	0	192.00

Dept Sub Total : 2,754.00
Dept Total : 2,754.00

OT Pharmacy(999311)

09-Sep-2023

1	36819	SODIUM CHLORIDE 1000ML (NIRLIFE) (HSN:30045020) (PMIN0125719421)	36819	09/09/2023 9:38	1	65.25	0	65.25
2	84397	CUROPINE 0.6MG/1ML INJ (PMIN0125719421)	84397	09/09/2023 9:38	2	9.60	0	9.60
3	95788	NS 100ML PLASTIC (CLARIS) (PMIN0125719421)	95788	09/09/2023 9:38	1	19.65	0	19.65

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.askapollo.com							Bill No : JBF-ICR-240508 Original Date of Service: 09/09/2023 By Joint Commission Internation: 26.70 0 26.70		
4	32925	EMESET 2MG 4ML INJ (PMIN0125719421)	32925	09/09/2023 9:38	1				
5	65429	SURGEN GOWN XL (REINFORCED) ##(HSN:9018) (PMIN0125719421)	65429	09/09/2023 9:38	2		700.00	0	700.00
6	91507	DERIPHYLIN 2ML INJ 7S (PMIN0125719421)	91507	09/09/2023 9:38	1		9.00	0	9.00
7	3036	DC ALCOHOL SWAB 100S ##(HSN:90189099) (PMIN0125719421)	3036	09/09/2023 9:38	2		4.00	0	4.00
8	58326	ANAWIN 0.5%20ML INJ(HSN:30049099) (PMIN0125719421)	58326	09/09/2023 9:38	1		88.26	0	88.26
9	64111	LIDFAST 2% GEL(HSN:30049099) (PMIN0125719421)	64111	09/09/2023 9:38	1		37.96	0	37.96
10	33940	LOX 2% ADRENALINE 30ML INJ(HSN:30039034) (PMIN0125719421)	33940	09/09/2023 9:38	1		35.27	0	35.27
11	36107	MEZOLAM 5ML INJ(HSN:30039034) (PMIN0125719421)	36107	09/09/2023 9:38	1		29.56	0	29.56
12	41046	PYROLATE 1 ML(HSN:30049034) (PMIN0125719421)	41046	09/09/2023 9:38	1		16.12	0	16.12
13	14493	RINGER LACTATE 500ML PLASTIC (B / BRAUN)(HSN:30049099) (PMIN0125719421)	14493	09/09/2023 9:38	1		72.76	0	72.76
14	33941	LOX 2% INJ(HSN:30039034) (PMIN0125719421)	33941	09/09/2023 9:38	1		31.24	0	31.24
15	64041	SURGICAL BLADES NO 11 (SWANN-MORTON)(HSN:9018) (PMIN0125719421)	64041	09/09/2023 9:38	1		42.50	0	42.50
16	45139	WATER FOR INJECTION 10ML (NIRMA) (HSN:30049099) (PMIN0125719421)	45139	09/09/2023 9:38	3		8.73	0	8.73
17	64725	BIATIN ALGINAT 10X10 37102(HSN:30051090) (PMIN0125719421)	64725	09/09/2023 9:38	1		365.00	0	365.00

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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For appointments or online consultation, visit www.apollo.com				IP No.	IP436535	Bill No.	JBH-GR-240538		
Name :	Mr. SAINATH REDDY	IP No.	IP436535	Organization	By whom generated	Date	365.00	0	365.00
18	64725	BIATIN ALGINAT 10X10 37102(HSN:30051090) (PMIN0125719421)	64725	09/09/2023 9:38	1		365.00	0	365.00
19	49425	CUTICELL-C 10CM x 10CM(HSN:3005) (PMIN0125719421)	49425	09/09/2023 9:38	1		37.00	0	37.00
20	1266	DC UNDER PAD 60X90CM ##(HSN:48189000) (PMIN0125719421)	1266	09/09/2023 9:38	1		99.00	0	99.00
21	59302	NEEDLE 16 1 1/2 (DISPOVAN)##(HSN:90183290) (PMIN0125719421)	59302	09/09/2023 9:38	1		4.40	0	4.40
22	46100	TOP GRIP 15CM X 4MTRS #(HSN:30059040) (PMIN0125719421)	46100	09/09/2023 9:38	2		790.00	0	790.00
23	25009	FENSTUD 50MCG/ML 2ML INJ(HSN:30049099) (PMIN0125719313)	25009	09/09/2023 9:40	1		56.00	0	56.00
24	49425	CUTICELL-C 10CM x 10CM(HSN:3005) (PMIN0125721111)	49425	09/09/2023 12:31	2		74.00	0	74.00
25	29323	VIATRAN 1.5GM INJ(HSN:30042019) (PMIN0125721111)	29323	09/09/2023 12:31	1		414.75	0	414.75
26	54022	ZOSTUM 1.5G INJ(HSN:30049087) (PMIN0125721257)	54022	09/09/2023 14:01	1		454.30	0	454.30
27	70828	KABIMOL 1% 100ML POUCH (PMIN0125721257)	70828	09/09/2023 14:01	1		600.00	0	600.00
28	46100	TOP GRIP 15CM X 4MTRS #(HSN:30059040) (PMIN0125723037)	46100	09/09/2023 16:51	1		395.00	0	395.00
29	70828	KABIMOL 1% 100ML POUCH (PMIN0125723414)	70828	09/09/2023 18:07	1		600.00	0	600.00
30	29323	VIATRAN 1.5GM INJ (PMIN0125723414)	29323	09/09/2023 18:07	1		414.75	0	414.75
Dept Sub Total :							5,865.80		
Dept Total :							5,865.80		

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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Name : Mr. SAINATH REDDY D

Professional Charges(999311)

Anaesthesiology

1	2122	Anaesthesiologist Fees (1524471)	Dr. SANATH REDDY P (ANAESTHESIOLOGY)	1	6,000.00	0	6,000.00
---	------	----------------------------------	--------------------------------------	---	----------	---	----------

General Surgery

1	2121	Surgeon Fees (1524471)	DR. SRINIVAS S (PODIATRIC)	1	24,000.00	0	24,000.00
						Dept Sub Total : 24,000.00	
						Dept Total : 30,000.00	

Ward Consumables(999311)

General OT

1	027747000002	HAND DISINFECTANT CHG PACK:500ML	1	410.00	0	410.00
	29563	MAKE:DOCTOR CHOICE (PMIS01937376)				

Dept Sub Total : 410.00
Dept Total : 410.00

Ward Pharmacy(999311)

09-Sep-2023

1	39166	ROCALTROL0.25 MCGCAP(HSN:30045036) (PMIS0125085009)	09/09/2023 12:07	1	31.24	0	31.24
2	46440	THYRONORM 25MCG TAB 120'S(HSN:30049082) (PMIS0125085009)	09/09/2023 12:07	1	1.61	0	1.61
3	71558	SEVANIX-400 TAB 10'S(HSN:30049099) (PMIS0125085009)	09/09/2023 12:07	1	25.90	0	25.90
4	32752	LIMCEE 500MG TAB(HSN:30045090) (PMIS0125085009)	09/09/2023 12:07	1	1.65	0	1.65
5	45949	ZINCOVIT TAB(HSN:21069099) (PMIS0125085009)	09/09/2023 12:07	1	7.00	0	7.00

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Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.apollo.com IP No : IF 436333

Bill No : JBH-CR-240538

Op Date : 09/09/2023 Expiry Date : 10/09/2023

Joint Commission International Accredited

			Date	Quantity	Unit Price	Line Total	Net Total	Net Total
6	33593	GABAPIN-300 MG CAP 15's(HSN:30049081) (PMIS0125085009)	09/09/2023 12:07	1			24.60	24.60
7	7433	NICARDIA RETARD 10MG TAB(HSN:30049072) (PMIS0125085009)	09/09/2023 12:07	1		3.12	0	3.12
8	34545	PANTOCID DSR CAP(HSN:30049039) (PMIS0125085009)	09/09/2023 12:07	1		14.33	0	14.33
9	82247	ENZOMAC TAB 15'S(HSN:30049099) (PMIS0125085009)	09/09/2023 12:07	1		24.79	0	24.79
10	51293	EPOFIT 6000IU/0.6ML PFS INF(HSN:3002) (PMIS0125085009)	09/09/2023 12:07	1		2,500.00	0	2,500.00
11	51905	MOXOVAS 0.2MG TAB(HSN:30049079) (PMIS0125085029)	09/09/2023 12:16	1		9.50	0	9.50
12	95849	BD ULTRAFINE III NANO PEN NEEDLES 4MM 32G#(HSN:90183220) (PMIS0125087956)	09/09/2023 19:40	5		96.00	0	96.00
13	8126	LANTUS SOLOSTAR 100IU INJ 3ML(HSN:30041090) (PMIS0125088017)	09/09/2023 19:40	1		769.01	0	769.01
14	79753	FIASP FLEXTOUCH 3ML/100U/ML(HSN:30043110) (PMIS0125088017)	09/09/2023 19:40	1		914.76	0	914.76

Dept Sub Total : 4,423.51

10-Sep-2023

1	30136	ALPRAX 0.5MG TAB(HSN:30049088) (PMIS0125089192)	10/09/2023 0:00	1		4.46	0	4.46
2	37485	ZOLFRESH 10MG TAB 15'S(HSN:30049082) (PMIS0125089192)	10/09/2023 0:00	1		9.53	0	9.53
3	54022	ZOSTUM 1.5G INJ(HSN:30049087) (PMIS0125089276)	10/09/2023 0:28	2		908.60	0	908.60
4	71558	SEVANIX-400 TAB 10'S(HSN:30049099) (PMIS0125089276)	10/09/2023 0:28	2		51.80	0	51.80

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Name : Mr. SAINATH REDDY To book appointments or online consultation, visit www.apollo.com Bill No : JBH-CR-240538

			Date	Quantity	Rate	Amount	CGST	SGST
5	45949	ZINCOVIT TAB(HSN:21069099) (PMIS0125089276)	10/09/2023 0:28	1		7.00	0	7.00
6	46440	THYRONORM 25MCG TAB 120'S(HSN:30049082) (PMIS0125089276)	10/09/2023 0:28	1	1.61	0	1.61	
7	38982	PANTODAC-DSR CAP 15'S(HSN:30049039) (PMIS0125089276)	10/09/2023 0:28	1	18.43	0	18.43	
8	82247	ENZOMAC TAB 15'S(HSN:30049099) (PMIS0125089276)	10/09/2023 0:28	2	49.58	0	49.58	
9	59438	MALIDENS I.V. 100ML(HSN:30049063) (PMIS0125089276)	10/09/2023 0:28	3	1,877.22	0	1,877.22	
10	51905	MOXOVAS 0.2MG TAB(HSN:30049079) (PMIS0125089276)	10/09/2023 0:28	2	19.00	0	19.00	
11	32752	LIMCEE 500MG TAB(HSN:30045090) (PMIS0125089276)	10/09/2023 0:28	2	3.30	0	3.30	
12	33642	GABANTIN 300MG CAP(HSN:30049081) (PMIS0125089276)	10/09/2023 0:28	1	21.90	0	21.90	
13	51293	EPOFIT 6000IU/0.6ML PFS INF(HSN:3002) (PMIS0125089276)	10/09/2023 0:28	1	2,500.00	0	2,500.00	
14	40465	SYRINGES 10ML BD (DISCARDIT)(HSN:30061020) (PMIS0125089615)	10/09/2023 1:47	3	102.00	0	102.00	
15	68149	DC WET WIPES##(HSN:9619) (PMIS0125089615)	10/09/2023 1:47	1	130.00	0	130.00	
16	80103	INTRAFIX SAFESET B.C.V. 180CM (B.BRAUN)(HSN:9018) (PMIS0125089615)	10/09/2023 1:47	2	816.00	0	816.00	
17	93498	SENSICARE NITRILE P/F EXAM GLOVES-L 100'S (MEDLINE) (PMIS0125089615)	10/09/2023 1:47	10	200.00	0	200.00	
18	75760	VIGGO-1WAY EXTENSION INFUSION SET 15CM(HSN:9018) (PMIS0125089615)	10/09/2023 1:47	1	365.00	0	365.00	

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Bill No : JBR-CR-240538

Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.apollo.com

Sl No.	Prescription No.	Item Description	Date	Quantity	Rate		
					Unit	Amount	Commission
19	46440	THYRONORM 25MCG TAB 120'S(HSN:30049082) (PMIS0125092673)	10/09/2023	1		1.61	
				15:05			
20	82247	ENZOMAC TAB 15'S(HSN:30049099) (PMIS0125092673)	10/09/2023	2		49.56	0
				15:05			
21	59438	MALIDENS I.V. 100ML(HSN:30049063) (PMIS0125092673)	10/09/2023	1		625.74	0
				15:05			
22	45949	ZINCOVIT TAB(HSN:21069099) (PMIS0125092673)	10/09/2023	1		7.00	0
				15:05			
23	71558	SEVANIX-400 TAB 10'S(HSN:30049099) (PMIS0125092673)	10/09/2023	2		51.80	0
				15:05			
24	34545	PANTOCID DSR CAP(HSN:30049039) (PMIS0125092673)	10/09/2023	1		14.33	0
				15:05			
25	32752	LIMCEE 500MG TAB(HSN:30045090) (PMIS0125092673)	10/09/2023	2		3.30	0
				15:05			
26	33642	GABANTIN 300MG CAP(HSN:30049081) (PMIS0125092673)	10/09/2023	1		21.90	0
				15:05			
27	51905	MOXOVAS 0.2MG TAB(HSN:30049079) (PMIS0125092673)	10/09/2023	2		19.00	0
				15:05			
28	54022	ZOSTUM 1.5G INJ(HSN:30049087) (PMIS0125092673)	10/09/2023	2		908.60	0
				15:05			
29	39166	ROCALTROL0.25 MCGCAP(HSN:30045036) (PMIS0125092672)	10/09/2023	1		31.24	0
				15:06			
30	39652	SODIUM CHLORIDE 9% 100ML (NIRLIFE) (HSN:30045020) (PMIS0125092755)	10/09/2023	1		22.03	0
				15:17			
31	40465	SYRINGES 10ML BD (DISCARDIT) #(HSN:30061020) (PMIS0125092755)	10/09/2023	5		170.00	0
				15:17			
32	42123	SYRINGES 5ML B.D.(HSN:90183100) (PMIS0125092755)	10/09/2023	5		90.00	0
				15:17			

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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EMERGENCY CALL - 1066

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"



Bill No : JBR-HCR-240538

Corporate Commission Accredited by Joint Commission International 625.74 0 625.74

Name : Mr. SAINATH REDDY Book appointments or online consultation, visit www.apollo.com

33	59438	MALIDENS I.V. 100ML(HSN:30049063) (PMIS0125092962)	10/09/2023 16:10	1	625.74	0	625.74
34	42795	DEXTROSE 25% 100ML PLA(NIRLIFE) (HSN:30045020) (PMIS0125093122)	10/09/2023 16:12	1	22.40	0	22.40
Dept Sub Total :						9,749.68	
11-Sep-2023							
1	35968	NICARDIA 10MG CAP(HSN:30049072) (PMIS0125095673)	11/09/2023 2:31	1	1.06	0	1.06
2	51293	EPOFIT 6000IU/0.6ML PFS INF(HSN:3002) (PMIS0125095673)	11/09/2023 2:31	1	2,500.00	0	2,500.00
3	68149	DC WET WIPES#(HSN:9619) (PMIS0125095700)	11/09/2023 2:59	1	130.00	0	130.00
4	27341	SODIUM CHLORIDE 0.9% 500ML (B BRAUN)(HSN:30045020) (PMIS0125095700)	11/09/2023 2:59	3	295.44	0	295.44
5	40465	SYRINGES 10ML BD (DISCARDIT) #(HSN:30061020) (PMIS0125095700)	11/09/2023 2:59	5	170.00	0	170.00
6	42123	SYRINGES 5ML B.D.(HSN:90183100) (PMIS0125095700)	11/09/2023 2:59	5	90.00	0	90.00
7	85774	SYRINGE 5ML POLYFLUSH (POLYMEDICURE) # (PMIS0125095700)	11/09/2023 2:59	5	325.00	0	325.00
8	62243	ECOFLAC PLUS NS 0.9% 100ML (B BRAUN)(HSN:9018) (PMIS0125095700)	11/09/2023 2:59	3	141.30	0	141.30
9	93852	ENLIVA NITRILE P/F GLOVES(M) 100S (PMIS0125095700)	11/09/2023 2:59	20	400.00	0	400.00
10	65515	GAMJEE PAD 30CM * 30CM(HSN:3005) (PMIS0125097825)	11/09/2023 12:12	2	208.00	0	208.00
11	49425	CUTICELL-C 10CM x 10CM(HSN:3005) (PMIS0125097825)	11/09/2023 12:12	2	80.00	0	80.00

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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EMERGENCY CALL - 1066

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"



Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.apollo.com

Bill No : JBR-HCR-240538

by Joint Commission International 98.48 0 5848

Sl No	Item No	Description	Date	Quantity	Rate	Tax	Total
12	27341	SODIUM CHLORIDE 0.9% 500ML (B BRAUN)(HSN:30045020) (PMIS0125097825)	11/09/2023	1	12:12		
13	46100	TOP GRIP 15CM X 4MTRS #(HSN:30059040) (PMIS0125097825)	11/09/2023	2	12:12	790.00	0 790.00
14	66553	DC ROLLER BANDAGE 15CM(HSN:3005) (PMIS0125097825)	11/09/2023	2	12:12	94.00	0 94.00
15	51325	GAUZE SWABS 7.5*7.5CM*12PLY(STERILE) #(HSN:3005) (PMIS0125097825)	11/09/2023	2	12:12	80.00	0 80.00
16	54022	ZOSTUM 1.5G INJ(HSN:30049087) (PMIS0125098149)	11/09/2023	1	12:41	454.30	0 454.30
17	39166	ROCALTROL0.25 MCGCAP(HSN:30045036) (PMIS0125098149)	11/09/2023	1	12:41	31.24	0 31.24
18	59438	MALIDENS I.V. 100ML(HSN:30049063) (PMIS0125098149)	11/09/2023	2	12:41	1,251.48	0 1,251.48
19	34545	PANTOCID DSR CAP(HSN:30049039) (PMIS0125098149)	11/09/2023	1	12:41	14.33	0 14.33
20	33642	GABANTIN 300MG CAP(HSN:30049081) (PMIS0125098149)	11/09/2023	1	12:41	21.90	0 21.90
21	46440	THYRONORM 25MCG TAB 120'S(HSN:30049082) (PMIS0125098149)	11/09/2023	1	12:41	1.61	0 1.61
22	35968	NICARDIA 10MG CAP(HSN:30049072) (PMIS0125098149)	11/09/2023	2	12:41	2.12	0 2.12
23	45949	ZINCOVIT TAB(HSN:21069099) (PMIS0125098149)	11/09/2023	1	12:41	7.00	0 7.00
24	29022	SANGOFIX ES (BLOOD SET) (HSN:90183990) (PMIS0125101541)	11/09/2023	1	20:36	211.00	0 211.00
25	42795	DEXTROSE 25% 100ML PLA(NIRLIFE) (HSN:30045020) (PMIS0125101541)	11/09/2023	2	20:36	44.80	0 44.80

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Name : Mr. SAINATH REDDY 

Bill No : JBH-CR-240538

By Joint Commission International 2.28 0 2.28

Sl No	Product ID	Product Description	Date	Time	Quantity	Dept Sub Total	Sub Total	Net Total
12-Sep-2023								
26	36441	PARACIP 650MG TAB(HSN:30049069) (PMIS0125101539)	11/09/2023	20:37	1			
1	34545	PANTOCID DSR CAP(HSN:30049039) (PMIS0125102656)	12/09/2023	0:09	1	14.33	0	14.33
2	29022	SANGOFIX ES (BLOOD SET) (HSN:90183990) (PMIS0125104147)	12/09/2023	8:00	1	211.00	0	211.00
3	42795	DEXTROSE 25% 100ML PLA(NIRLIFE) (HSN:30045020) (PMIS0125104154)	12/09/2023	8:00	1	22.40	0	22.40
4	39166	ROCALTROL 0.25 MCGCAP(HSN:30045036) (PMIS0125105133)	12/09/2023	10:52	1	31.24	0	31.24
5	43806	ULTRACET TAB 15'S(HSN:30049069) (PMIS0125108168)	12/09/2023	16:17	6	104.40	0	104.40
6	35971	NICARDIA RETARD 20MG TAB(HSN:30049072) (PMIS0125108184)	12/09/2023	16:17	6	25.62	0	25.62
7	71558	SEVANIX-400 TAB 10'S(HSN:30049099) (PMIS0125108197)	12/09/2023	16:17	6	155.40	0	155.40
8	51293	EPOFIT 6000IU/0.6ML PFS INF(HSN:3002) (PMIS0125108193)	12/09/2023	16:17	1	2,500.00	0	2,500.00
9	39166	ROCALTROL 0.25 MCGCAP(HSN:30045036) (PMIS0125108177)	12/09/2023	16:18	3	93.72	0	93.72
10	82247	ENZOMAC TAB 15'S(HSN:30049099) (PMIS0125108217)	12/09/2023	16:19	1	24.78	0	24.78
11	82247	ENZOMAC TAB 15'S(HSN:30049099) (PMIS0125108217)	12/09/2023	16:19	5	123.90	0	123.90
12	46440	THYRONORM 25MCG TAB 120'S(HSN:30049082) (PMIS0125108217)	12/09/2023	16:19	3	4.83	0	4.83

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Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.apollo.com

Bill No : JBR-HCR-240538

by Joint Commission International 21.00 0 0.00

Sl.	MRN	Item Description	Date	Quantity	Rate	Tax	Total
13	45949	ZINCOVIT TAB(HSN:21069099) (PMIS0125108217)	12/09/2023 16:19	3			
14	33642	GABANTIN 300MG CAP(HSN:30049081) (PMIS0125108217)	12/09/2023 16:19	3	65.70	0	65.70
15	32752	LIMCEE 500MG TAB(HSN:30045090) (PMIS0125108217)	12/09/2023 16:19	6	9.90	0	9.90
16	34545	PANTOCID DSR CAP(HSN:30049039) (PMIS0125108217)	12/09/2023 16:19	3	42.99	0	42.99
17	51905	MOXOVAS 0.2MG TAB(HSN:30049079) (PMIS0125108217)	12/09/2023 16:19	6	57.00	0	57.00

Dept Sub Total : 3,508.21
Dept Total : 25,126.74

(B) indicates bedside service

(S) indicates stat service

(E) indicates dead patient

Dual Occupancy

Bed Details

Sl.No	From Date	To Date	Duration	Bed No	Bed Category
1	09-Sep-2023 7:20 am	09-Sep-2023 6:12 pm	0Days 10Hrs 52Mins	R-10	Private
2	09-Sep-2023 6:12 pm	12-Sep-2023 4:27 pm	2Days 22Hrs 14Mins	313	Private

Payer Payable Total : 134,620.00

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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 Apollo Health City campus, Jubilee Hills, Hyderabad - 500 096.
 +91-1860 258 1066
 apollohealthcity@apollohospitals.com  www.apollohealthcity.com
 [apollohealthcity](#)  [apollohealthhyd](#)  [apollohealthcityhyd](#)

Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.apollo.com



Bill No : JBH-ICR-240538
by Joint Commission International

Grand Total :

134,620.00

Disclaimer : *All the above dates indicated as Date & Time of the entry only

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Regd. Office : Apollo Hospitals Enterprise Limited, No. 19, Bishop Garden, Raja Annamalaipuram, Chennai - 600 028, Tel: +91-44-28293333, Fax: +91-44-28290956
Corporate Identity Number (CIN) : L85110TN1979PLC008035



EMERGENCY CALL - 1066

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"



Name : Mr. SAINATH REDDY For appointments or online consultation, visit www.apollo.com

Bill No : JBHFOR-240538

by Joint Commission International

SI No.	Doctor's Name	Specialization	OT Request No
1	Dr. SANATH REDDY P	ANAESTHESIOLOGY	1524471
2	DR. SRINIVAS S	PODIATRIC	1524471
3	Dr. SANJAY MAITRA	NEPHROLOGY	6881450
4	Dr. SANJAY MAITRA	NEPHROLOGY	6886373

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Regd. Office : Apollo Hospitals Enterprise Limited, No. 19, Bishop Garden, Raja Annamalaiapuram, Chennai - 600 028, Tel: +91-44-28293333, Fax: +91-44-28290956
Corporate Identity Number (CIN) : L85110TN1979PLC008035



EMERGENCY CALL - 1066

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"

Diabetic Chart Report :

Print Out Date & Time : 13-Sep-2023 9:57:48

Regd Office : Apollo Hospitals Enterprise Limited

Patient Name: Mr. SAINATH REDDY D

Age :

71Yr 3Mth 27Days

Gender : Male

UHID : APJ1.0001607472

Patient Identifier : IP436335

Diabetic Chart :

Created by	Created date	Blood sugar	Blood sugar type	Capture time	Informed doctor	Informed time	Route	Insulin & Other Information
Ms. Aleena Tomy	9/12/2023 8:09:20AM	125	Post Lunch	00:00		00:00		
Ms. Navya D	9/11/2023 1:05:05AM	111	FBS	00:00		00:00		
Ms. Anupama Jayaprakash	9/10/2023 2:09:44PM	126	Pre Dinner	00:00		00:00		
Ms. Aleena Tomy	9/10/2023 8:03:01AM	112	Pre Lunch	00:00		00:00		
Ms. Navya D	9/10/2023 1:43:58AM	111	FBS	00:00		00:00		
Mr. Raja Annamalai	9/11/2023 2:25:32PM	210	Pre Lunch	00:00		00:00		
Ms. Navya D	9/12/2023 1:44:06AM	111	FBS	00:00		00:00		
Ms. Navya D	9/9/2023 6:30:55PM	122	Pre Dinner	00:00		00:00		

"KEEP THE REPORTS CAREFULLY AND BRING THEM ALONG DURING YOUR NEXT VISIT TO OUR HOSPITAL"

EMERGENCY CALL - 1066

Page No. 1

Page No. 1

Page 1 of 1

Apollo Health City campus, Jubilee Hills, Hyderabad - 500 096.
+91-1860 258 1066
apollohealthcity@apollohospitals.com www.apollohealthcity.com
apollohealthhyd.com www.apollohealthcityhyd.com

For appointments or online consultation, visit www.askapollo.com



Apollo
HOSPITALS



Patient Details

UHID: APJ1.0001607472 IP No: IP436335
Name: Mr. SAINATH REDDY D
Age: 71Yr 3Mth 26Days Sex: Male
Address: LAXMI NAGARAM VILLAGE VELDURTHY MANDAL,Kurnool,Andhra Pradesh
Bed Details: 3rd FloorSpecial Ward, R. No. 313, Bed no:313
Date Of Admission: 09-Sep-2023 Date Of Discharge: 12-Sep-2023

Investigations Done

BioChemistry

GLYCOSYLATED HEMOGLOBIN (HbA1C) - WHOLE BLOOD

12-Sep-2023 01:56 PM

GLYCOSYLATED HEMOGLOBIN (HbA1C) - WHOLE BLOOD	5.6 %	HbA1C Degree of Control
		Less than 5.7 Normal 5.8-6.4 Pre Diabetes Greater than 6.5 Diabetes cutoff

Haematology

HEMOGLOBIN (AUTOMATION)

09-Sep-2023 03:58 PM

HEMOGLOBIN (Method:Spectrophotometry)	6.9 g/dl	13.0-17.0
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11-Sep-2023 06:39 AM

HEMOGLOBIN (Method:Spectrophotometry)	7.2 g/dl	13.0-17.0
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Microbiology

CULTURE AND SENSITIVITY (TISSUE)

09-Sep-2023 09:23 AM

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