PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Name of the Hospital: INDIRA GANDHI CO-OPERATIVE HOSPITAL

Hospital Location: MANJODI THIRUVANCHAM Hospital ID:

Hospital Fax No: Hospital Phone No: 04902325411

DETAILS OF THIRD PARTY ADMINISTRATOR

(To be Filled in block letters)

a) Name of TPA / Insurance company: Medi Assist India TPA Pvt Ltd,

b) Toll Free Phone Number: 1800 425 9449

b) Toll Free FAX Number: 1800 425 9559

To Be filled in By Insured / Patient

a) Name of the Patient: PRASEENA.K FIRST NAME MIDDLE NAME

b) Gender: ☐ Male ☑ Female c) Age: Years 53 Months MM d) Date of birth DD MM YY

e) Contact number: f) Insured Card ID Number: 2C8579912

g) Policy number / Name of corporate: h) Employee ID: 224855

h) Currently do you have any other Mediclaim / Health Insurance: ☐ Yes ☐ No Company Name

Give details:

i) Do you have a family physician ☐ Yes ☐ No j) Name of the family physician

k) Contact number, if any: (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATINGDOCTOR/HOSPITAL

a) Name of the treating doctor: DR. RESHMA.V.M b) Contact Number:

c) Name of ILLNESS / Disease with presenting complaints: Post menopausal bleed - 1 day

d) Relevant clinical findings:

e) Duration of the present ailment: Days f) Date of first consultation DD MM YY ii. Past history of present ailment if any:

f) Provisional diagnosis: Post menopausal bleed. For D&E & biopsy

iii. ICD 10 Code:

g) Proposed line of treatment: ☐ Medical Management ☑ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

h) If investigation & / or Medical Management provide details: i.Route of drug administration:

i) If Surgical, name of surgery: D&E & biopsy i. 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: MM YY YY 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: ☐ Yes ☐ No (If Yes attach reports)

m) In case of Maternity: ☐ G ☐ P ☐ L ☐ A Date of Delivery: DD MM YY

Details of the patient admitted

a) Date of admission: 15 12 23 b) Time HH MM

c) Is this an emergency / a planned hospitalization event?: ☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital: 003 Days e) Room Type: Vip AC Room

f) Per Day Room Rent + Nursing & Service charges + Patient's Diet: Rs. 4000/day

g) Expected cost for investigation + diagnostics: Rs. 3000

h) ICU Charges: Rs.

i) OT Charges: Rs. 8000

j) Professional fees Surgeon + Anesthetist Fees + Consultation Charges: Rs. 15000

k) Medicines + Consumables _ Cost of Implants (if applicable please specify), Other hospital expenses if any: Rs. 6000

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

m) Sum Total expected cost of hospitalization: Rs. 44000

Mandatory: Past History of any chronic illness — If yes, since (Month / year)

- ☐ Diabetes MM YY
- ☐ Heart Disease MM YY
- ☐ Hypertension MM YY
- ☐ Hyperlipidemias MM YY
- ☐ Osteoarthritis MM YY
- ☐ Asthma / COPD / Bronchitis MM YY
- ☐ Cancer MM YY
- ☐ Alcohol or drug abuse MM YY
- ☐ Any HIV or STD / Related ailments MM YY

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read understood and agreed to the Declaration on the reverse of this form

a) Name of the treating doctor: DR. RESHMA.V.M FIRST NAME MIDDLE NAME

b) Qualification: c) Registration No. with State Code:

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature: Pramod.K.C.

IMPORTANT: PLEASE TURN OVER

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. 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.

2. 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.

3. All non-medical expenses and expenses not relevant to current hospitalization and the amount over & above the limit authorized by the Insurer/T.P.A. not governed by the terms and conditions of the policy will be paid by me.

4. I hereby declare to abide by the terms and conditions of the policy and if at any facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / T.P.A.

5. I agree and understand that T.P.A. is in no way warranting the service of the hospital & that the Insurer / TPA is no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

6. 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.

7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer / TPA.

a) Patient's / Insured's Name: Praseena. K. K.

b) Contact Number: 9744089999 c) Patient's / Insured's Signature:

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaing to hospitalization

2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent TPA / Insurance Company within 7 days of the patient's discharge.

2. All non medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co. OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.

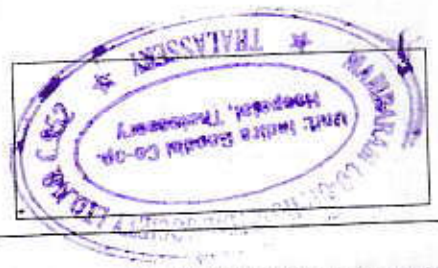
4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.

5. The patient declaration has been signed by the patient or by his represent in our presence.

6. We agree provide clarification for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal



Doctor's Signature

Dr. RESHMA V.M.
MBBS, DGO, DNB, Consultant Gynaecologist
REG No. 21696
INDIRA GANDHI CO-OPERATIVE HOSPITAL
MANJODI, THALASSERY-3

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.

NEW INDIA ASSURANCE

Beneficiary name:	Sidharth P P
Member ID:	18459091
Employee code:	2248655
Relation:	Self
Date of birth:	17-Nov-1996
Primary insured:	Sidharth P P
Valid upto:	31-Oct-2023
Policy holder:	Cognizant
Insurer ID:	–

CA18459091

Contact number: 1800 258 5895

- 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 Network hospital list, login to www.mediassist.in

Medi Assist Insurance TPA Pvt. Ltd.

Tower D, 4th Floor, IBC Knowledge Park, 4/1, Bannerghatta Road, K.M.Layout, Bengaluru, Karnataka 560029.CIN: U85199KA1999PTC025676

Website: www.mediassist.in Email: cts@mediassistindia.com

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NEW INDIA ASSURANCE

Beneficiary name:	Praseena KK
Member ID:	26857992
Employee code:	2248655
Relation:	Mother
Date of birth:	05-May-1957
Primary insured:	Sidharth P P
Valid upto:	31-Oct-2023
Policy holder:	Cognizant
Insurer ID:	–

CA26857992

Contact number: 1800 258 5895

- This card is only for identification and is not an authorization to proceed with the treatment or a guarantee for payment.
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Website: www.mediassist.in Email: cts@mediassistindia.com

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ഭാരത സർക്കാർ
GOVERNMENT OF INDIA

PRASEENA K K
ജനന തീയതി/ DOB: 05/05/1967
സ്ത്രീ / FEMALE

2544 5577 3916

ആധാർ - സാധാരണക്കാരന്റെ അവകാശം

ഭാരതീയ സവിശേഷ തിരിച്ചറിയൽ അതോറിറ്റി
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

വിലാസം:
D/O സി കെ നാരു, സിധാർത്ഥ്,
നെടുവോട്ടുംകുന്ന്, മട്ടന്നൂർ പി ഒ, മട്ടന്നൂർ(മു),
കണ്ണൂർ,
കേരള - 670702

Address:
D/O C K Nanu, SIDHARTH,
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Kannur,
Kerala - 670702

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