

## HCL Technologies Ltd-IOMC Division.

### HOSPITALIZATION TREATMENT CLAIM SUMMARY FORM

EMPLOYEE DETAILS		MEDICAL CYCLE: 2021-22		
Claim No. : 682552	No. of Claim Entries : 1	Total Claim : 33936.00	Status : Submitted	
Name : Vaishnavi M		EmpCode : 51702580	DOJ : 01 Sep 2017	
Email ID : VAISHNAVIM@HCL.COM		Landline/Mobile : 7299187923	PayRollAreaCode : 2C	
Payee Name : Vaishnavi M		Bank Name : Axis Bank		
IFSC Code : UTIB0002201		Account No. : 916010068525524		

PATIENT'S DETAILS		
Name : SUMATHI MURALIDHARAN	Relation with the Employee : mother	Age : 54

CLAIM DETAILS	
Name of Hospital : Dr. Parthasarathy Memorial Hospital 20,Shastri Nagar Main road, near Kakkan bridge bus stop Adambakkam, Chennai - 600088 TamilNadu	
Date of admission : 11/5/2021	Date of Discharge : 11/5/2021

#	Description	Amount	Claimed(Y/N)	Remarks
1	Room Charges for Patient	500.00		
2	Room Charges for Attendant/Guests	0.00		
3	Test(s) /X-Charges	850.00		
4	Medicine Expenses	1,686.00		
5	Doctor's Fee	400.00		
6	Operation Theater Charges	3,000.00		
7	Surgery Charges	21,500.00		
8	Nursing Charges	0.00		
9	Any Other Charges(give brief details)	6,000.00		
Total Claim Amount		33,936.00		

This is to confirm that the below given items as checked are being provided from my end and they are genuine and correct as per my understanding.

Original Discharge summary	<input checked="" type="checkbox"/>
Discharge Summary should include	<input checked="" type="checkbox"/>
It should be on the Hospital Letter Head	<input checked="" type="checkbox"/>
The letter head should bear hospital address, telephone nos., email id, fax nos. etc	<input checked="" type="checkbox"/>
Name of the patient, Age, Gender	<input checked="" type="checkbox"/>
Referred from/By	<input type="checkbox"/>
IP No	<input type="checkbox"/>
Date & time of Admission & Date & time of discharge	<input checked="" type="checkbox"/>
Name of the treating doctor / s	<input type="checkbox"/>

	<input checked="" type="checkbox"/>
Final Diagnosis	<input checked="" type="checkbox"/>
Provisional Diagnosis	<input type="checkbox"/>
Chief Complaints/Presenting complaints	<input checked="" type="checkbox"/>
Past History of Presenting illness with duration	<input type="checkbox"/>
History of any other ailment, treatment, consultation etc. with Personal History	<input type="checkbox"/>
Menstrual History in case of female patients	<input type="checkbox"/>
General Physical Examination, Vitals	<input type="checkbox"/>
Systemic Examination	<input type="checkbox"/>
Investigations done at the hospital and elsewhere and Findings	<input checked="" type="checkbox"/>
Treatment given in detail	<input type="checkbox"/>
Surgery Details with Date of Surgery, Procedure, Type of Anaesthesia, Name of the Surgeon, Asst Surgeon, Anaesthetist, Procedure Notes	<input checked="" type="checkbox"/>
Course in the hospital	<input type="checkbox"/>
Condition at Discharge	<input checked="" type="checkbox"/>
Discharge Advice and Medications	<input checked="" type="checkbox"/>
Follow-up Instructions	<input type="checkbox"/>
Signed by the Surgeon/Medical Superintendent/ Doctor who treated the patient	<input checked="" type="checkbox"/>
In case of maternity, details of Gravida ( GPAL – Gravida / Para / Abortion / Living children ) to be given	<input type="checkbox"/>
Original Medicine Bills	<input checked="" type="checkbox"/>
Original Reports/ Tests	<input checked="" type="checkbox"/>
Original Bills of reports/ Tests	<input checked="" type="checkbox"/>
Break up details for hospitalization Final bill	<input checked="" type="checkbox"/>
Pre numbered cash paid receipt for Hospitalization Payment	<input checked="" type="checkbox"/>
Signed Discharge Voucher	<input checked="" type="checkbox"/>
Signed Print out of the Claim Form	<input checked="" type="checkbox"/>
Staple all the supports carefully to ensure there is no loss in transit	<input checked="" type="checkbox"/>

### CLAIM HISTORY

Date	Status	Name	Remarks
11-Nov-2021	Submitted	Vaishnavi M	

### Declaration

I hereby agree, affirm and declare that:

1. The statements/information given/stated by me/us in this claim form are true, correct and complete.
2. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
3. If I have given/made any false or fraudulent statement /information /Documents, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past,present or future. Further, I am aware that submission of fraudulent claims can lead to disciplinary action under the Company policies up to and including termination.
4. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
5. I have read and understood the indicative list of Over the Counter Drugs.
6. Non Medical items are not payable under the policy.
7. I have read and understood that treatment for Cosmetic/Acne /Alopecia (Hair fall treatment)/ Malasma /hypo pigmentation / Infertility & Contraception related treatment/ HIV related Problem / Congenital External diseases is not payable.

**Please note that before dropping the claim, you have to enter claim information in the medical**

**register which is kept on the medical claim drop box.**

Place:

Date: Nov 11, 2021

Important:

Since it is a pre-requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the Insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the same on the Bill-cum-Receipt issued by them.

**Signature of Insured Employee**

**AUTHORISATION LETTER TO VIDAL HEALTH TPA PVT. LTD.,**

To

The Medical Superintendent

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Sub: Request to verify /obtain copies of the Medical Records

I have undergone treatment for-----

From----- to----- in your hospital / Clinic under

I consent & authorize my insurer (Oriental Insurance Company) and it TPA Vidal Health TPA Pvt Ltd., to seek necessary medical information from the hospital / Medical Practitioner with regards to the settlement of this Medical claims.

Pls. provide the necessary help and inputs required for the same information/records required by the insurance. I have no objection whatsoever in this regard.

Thanking you,

Signature of the Patient:

Name of Patient:

Place:

Signature of the Employee:

Name of Employee:

Date: