Reg. No. : 202

SUSHILA HOSPITAL

Dr. Santosh Agrawal
Reg. No.: 65719
MS (Ophth) Gold Medalist
DNB (MNAMS), Diplomat of
National Board, Delhi
Fellow, Sankara Netralay (Chennai)
Mob No. : 9325382000 / 9689360352

8, Bansilal Nagar, In front of Bikaner sweet shop,
Railway Station Road, Aurangabad – 431 005 M.S. (India)
Ph.:0240-2321638, Mob No. 8657240794 / 9518746277
Web. : www.drsantoshagrawal.in, Email: drsantoshagrawal@gmail.com

BILL OF OPERATION

Date: 19/05/2023

Bill No :- 6575

Patient Name : - Mrs. Nirmala Ladniya
Address : - Jyoti nagar, Aurangabad
Surgeon Name: - Dr. Santosh Agrawal
Surgery Name : - P+ IOL in Right eye

DOA: 19/05/2023 DOD: 20/05/2023

Particulars	Amount
Surgeon Charges	16,000/-
Indoor Charges	2,000/-
O.T Charges	12,000/-
Monofocal IOL Charges	18,000/-
Anesthetic Charges	2,000/-
Total	50,000/-

(Rs. Fifty Thousand Only)
Towards Operation Charges.

Dr. Santosh H. Agrawal
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Dr. Santosh Agrawal
(Reg. No. : 65719)

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Date: - 19/05/2023

CERTIFICATE

TO WHOM SOEVER IT MAY CONCERN

This Is to Certify That **Mrs. Nirmala Ladniya Age – 65** Yrs Female

Has Been Under My Treatment from **19/05/2023** to **20/05/2023.**

She Has Undergone **P+IOL in Right Eye on 19/05/2023.**

She Was Admitted On **19/05/2023** & Discharged On **20/05/2023**.

Hence Certified.

Dr. Santosh H. Agrawal
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Dr.Santosh Agrawal
{Reg. No. 65719}

Reg. No. : 202

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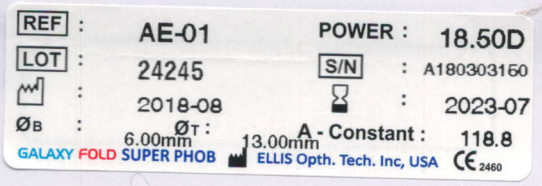
LENSE STICKER

Name of the Patient	: - Mrs. Nirmala Ladniya
Age	: - 65 yrs / Female
Address	: Jyoti Nagar, Aurangabad
Date of operation	: - 19/05/2023
Surgery Name	: - Phaco + IOL in Right Eye



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RECEIPT

Date: 19/05/2023

Receipt No: - 6575

Received with thanks from **Mrs. Nirmala Ladniya Age 65** years,

Female the sum of Rs. **Fifty Thousand Only.**

{Total Rs. 50,000/-) By Card Swipe (*UTR No.4917870061***)**

Towards Operation Charges.

Dr. Santosh H. Agrawal
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Dr. Santosh Agrawal

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SUSHILA NETRALAY

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Web. : www.drsantoshagrawal.in, Email: drsantoshagrawal@gmail.com

DATE: - 19/05/2023

A-SCAN REPORT

Patient Name	: -	**Mrs. Nirmala Ladniya**
Age / Sex	: -	65 Years / Female
Address	: -	Jyoti Nagar, Aurangabad
A-Scan	: -	**Right Eye**
Kv	: -	44:98 D
Kh	: -	44:28 D
AL	: -	24:44mm

IOL Power	:-	**118.5**	**118.0**
		17.23	**16.73D**
		16.50	0.26D
		17.00	- 0.12D
		17.50	- 0.52 D
		18.00	**- 0.92 D**
		18.50	**- 1.01 D**

Selected Monofocal IOL Power + 18.50 D

Hence Certified

Dr. Santosh H. Agrawal
M.S.(Ophthalmology) Gold Medal. DNB
FMRF (Madras). Reg.No : 65719
SUSHILA HOSPITAL, Bansilal Nagar, A;bad.

Dr. Santosh Agrawal
Reg. No. 65719

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)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital: Sushila Hospital

b) Hospital ID:

c) Type of Hospital: Network ☐ Non Network ☑ (If non network fill section E)

d) Name of the treating doctor: Dr. Santosh Agrawal

e) Qualification: MS Ophthal Gold Medal

f) Registration No. with State Code: 65719

g) Phone No. 0240-2321638

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: Mrs Nirmala Ladniya

b) IP Registration Number: 6575

c) Gender: Male ◯ Female ⊙

d) Age: Years 65 Months

e) Date of birth:

f) Date of Admission: 19-05-2023

g) Time: 10.00

h) Date of Discharge: 20-05-2023

i) Time:

j) Type of Admission: Emergency ☐ Planned ☑ Day Care ☐ Maternity ☐

k) If Maternity i. Date of Delivery:

ii. Gravida Status:

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

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:		Decrease of Vision in RE	i. Procedure 1:		
ii. Additional Diagnosis:		Matured Cataract in RE	ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:	P+IOL in Right eye	

c) Present ailment is a complication of PED? ☐ Yes ☑ No (If Yes, specify details)

d) Pre-authorization obtained: ☐ Yes ☑ No e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) 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:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID 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 report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital: Sushila Hospital
Plot No.8 Bansilalnagar Station Road Aurangabad
City: Aurangabad State: Maharashtra
Pin Code: 431005

b)Phone No. 2402321638

c) Registration No.: 202

d) PAN: AAPPA5532N

e) Number of Inpatient beds 05

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

iii. Others: Special Modular Operation theater

SECTION F

DECLARATION BY THE INSURED

(PLEASE READ VERY CAREFULLY)

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited.I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made.I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post hospitalization claim, if any.

Date: 20-05-2023 Place: Aurangabad Signature of the Insured:

SECTION G

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

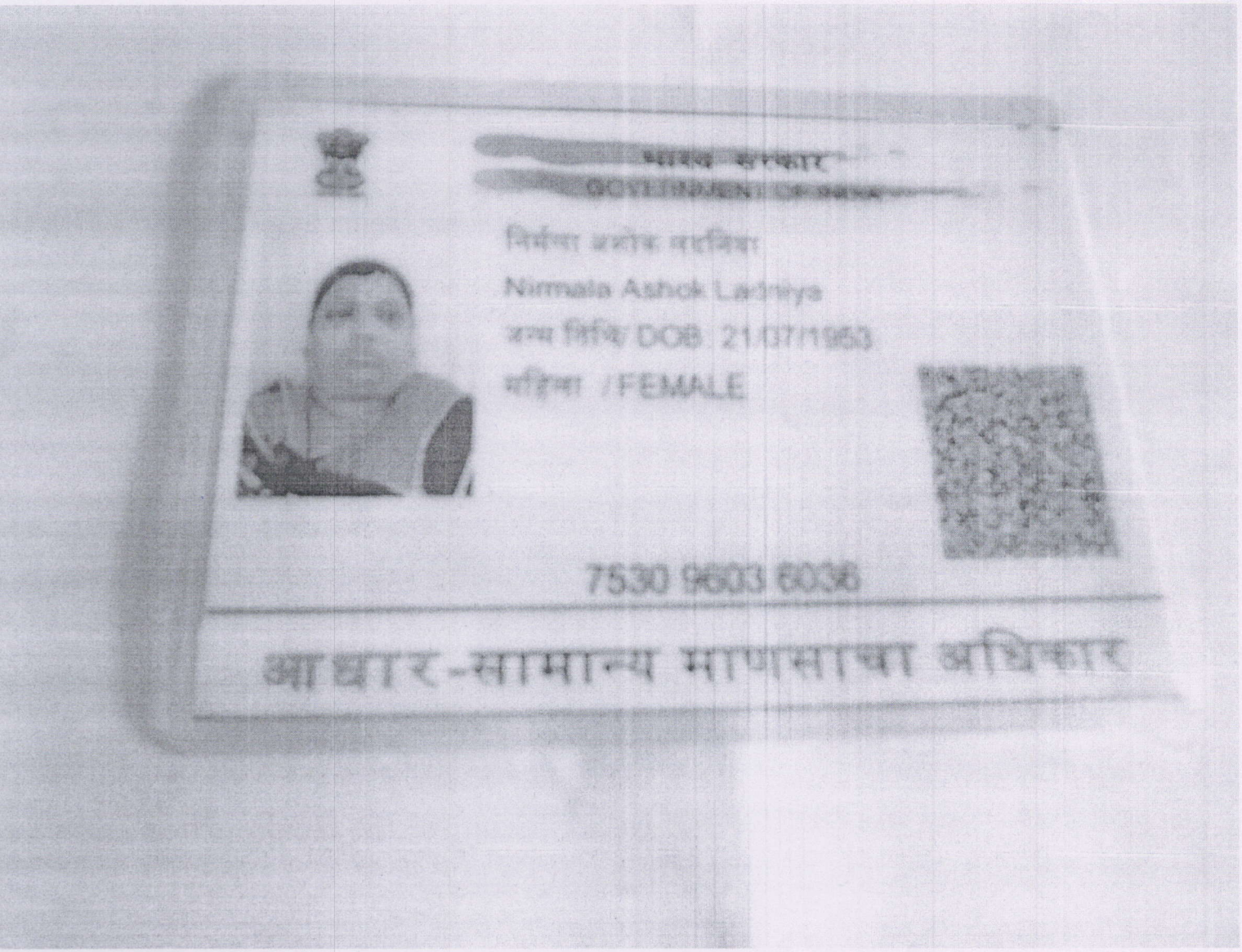
We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: D D M M

Place: CH, Sambhajinagar

Signature and Seal of the Hospital Authority:

Dr. Santosh H. Agrawal
M.S.(Ophthalmology) Gold Medal. DNB
FMRF (Madras). Reg.No : 65719
SUSHILA HOSPITAL, Bansilal Nagar, A;bad.



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