GOVERNMENT OF WEST BENGAL
OFFICE OF THE CHIEF MEDICAL OFFICER OF HEALTH
DEPARTMENT OF HEALTH & FAMILY WELFARE
PASCHIM BARDHAMAN
KALYANPUR, ASANSOL-713 305

Email. cmoh.asnsl@gmail.com Ph. No-0341-2999002

MEMO. NO.CMOH/PAS.BDN/ 2012 **DATE,** 15 / 07 **/2022**

From : The Chief Medical Officer of Health,
Paschim Bardhaman.

To: ***The Proprietor/Director/Medical Superintendent,***
Advanced Laparoscopic & Medical Centre, Sen-Releigh Rd.
Asansol, Paschim Bardhaman-713305

Subject : Treatment particulars of Shri Bhajan Ghosh

Sir,

Whereas, a letter being received from ADM(G), Paschim Bardhaman vide Memo. No.238/JM/22, dated 24/05/2022 i.c.w. complaint of Sri Bhajan Ghosh, of Kalyanpur Housing Estate, Asansol, seeking treatment particulars from hospital authority for claim/reimbursement of medical charges from the insurance company(i.e.Care Health Insurance).

Whereas, The National Human Rights and Crime Control Bureau, vide ref. no.NHRCCB/WB/27, dated 22/04/2022 seeking treatment particulars from your end on behalf of Sri Bhajan Ghosh.

Therefore, As per CE Act.2017 the Advanced Laparoscopic & Medical Centre, Sen-Releigh Rd. Asansol, Paschim Bardhaman-713305 is hereby directed to send all treatment particulars directly to the complainee with a copy to The National Human Rights and Crime Control Bureau, office address-Duplex No.2&4, Town House, Block-5, Bengal Shristi Pvt. Ltd., Shristinagar, New Asansol, Asansol-713304(9470104679/9933581779) and send one copy to the undersigned immediately.

The action should be taken within 72 hrs. of this memo.

Enclo : As stated

15/07/22

Chief Medical Officer of Health
Paschim Bardhaman

MEMO. NO.CMOH/PAS.BDN/ 2012 **/1(6)** **DATE,** 15 / 07 **/2022**

Copy forwarded for information & necessary action please.:

1. The A.D.M.(G), Paschim Bardhaman
2. Dy. C.M.O.H.-I, Paschim Bardhaman
3. The CA to the District Magistrate, Paschim Bardhaman.
4. The National Human Rights and Crime Control Bureau, office address-Duplex No.2&4, Town House, Block-5, Bengal Shristi Pvt. Ltd., Shristinagar, New Asansol, Asansol-713304(9470104679/9933581779).
5. Sri Bhajan Ghosh, Kalyanpur Housing Estate, Asansol, Paschim Bardhaman-713305
6. Office Copy

15/07/22

Chief Medical Officer of Health
Paschim Bardhaman

File No.PSBDN-26013(99)/12/2022-JM SEC

Dy. CALO-I
26/05/22

Docket No. 2666 Dated 26/5/2022
C. M. O. H., Paschim Bardhaman

Government of West Bengal
Office of the District Magistrate & Collector Paschim Bardhaman
Judicial Munshikhana Scetion
Email-jmpaschimbdn@gmail.com, Phone No- 0341-2970023

Memo No. 238/J.M/22 **Date.** 24/05/22

HC
draft a letter to the said hospital to go through all paper & do accordingly.
27/05/22

To
The Chief Medical Officer of Health
Paschim Bardhaman
Kalyanpur,Asansol-713305.

Sub:-Complaint of Sri Bhajan Ghosh of Kalyanpur Housing Estate, Asansol forwarded by Sri Abhik Chatterjee President, West Bengal,The NATIONAL HUMAN RIGHTS AND CRIME CONTROL BUREAU.
Ref :-. No. NHRCCB/WB/27 dated 22/04/2022.

Sir,

Enclosed please find herewith the complaint of Sri Bhajan Ghosh of Kalyanpur Housing Estate, Asansol forwarded by Sri Abhik Chatterjee President, West Bengal,The NATIONAL HUMAN RIGHTS AND CRIME CONTROL BUREAU, vide ref. no NHRCCB/WB/27 dated 22/04/2022.. which will speak for itself.

You are requested to cause an enquiry and take necessary action at an early date.

Enclo:- As stated above.

Signed by Shevale Abhijit Tukaram
Date: 24-05-2022 11:13:24
Reason: Approved

Additional District Magistrate (G)
Paschim Bardhaman

Memo No. 238/1(2)/J.M./22 Digitally Signed by Addl District Magistrate Paschim Bardhaman **Dated:-** 24/05/2022

Copy to

1. Sri Abhik Chatterjee President, West Bengal,The NATIONAL HUMAN RIGHTS AND CRIME CONTROL BUREAU., Duplex No.2&4, Town House, Block-5, Bengal Shristi Pvt. Ltd. , Shristinagar, New Asansol-713304.
2. C.A to the Hon'ble District Magistrate, Paschim Bardhaman.

Additional District Magistrate (G)

Digitally Signed by Addl District Magistrate Paschim Bardhaman

Abhik Chatterjee
President, West Bengal

UIN ID. : NHRCCB/ 0647
Mob. : +91 9470104679
+91 9933581779
abhikchatterjeenhrccb@gmail.com

NATIONAL HUMAN RIGHTS AND CRIME CONTROL BUREAU

(GOVT. REGD. 483/2017, INCORPORATED UNDER THE LEGISLATION OF GOVT. OF INDIA, I.T.A. 1882)
REGD. UNITED NATION (UNDESA), NITI AAYOG (GOVT. OF INDIA)
A VOLUNTARY ORGANIZATION FOR THE PROTECTION & PROMOTION OF HUMAN RIGHTS

Ref. No. NHRCCB/ WB/27

O/C NHRC

Date : 22-04-202

Office of the District Magistrate & Collector
Paschim Bardhaman
Received Docket No : 2934
Date 11/05/22
Section :

To
The Superintendent
Advanced Laparoscopic and Medical Centre
Sen-Raleigh Road
Asansol.

মহাশয়, আমরা National Human Rights and Crime Control Bureau-র পক্ষ থেকে শ্রী ভজন ঘোষ, As-8/2/2, কল্যাণপুর হাউজিং, আসানসোল-৫ এর বাসিন্দা অভিযোগের ভিত্তিতে আপনাকে লিখিত ভাবে জানাতে বাধ্য হচ্ছি যে, শ্রী ভজন ঘোষের পুত্র শ্রী সুপ্রিয় ঘোষ গত 6/5/2021 কারিরিক অসুস্থতা নিয়ে আপনাদের Centre-এ ভর্তি হন, শ্রী ভজন ঘোষের family Mediclaim রয়েছে (Care Health Insurance Policy no 17340422), Patient 6/5/21 থেকে 9/5/21 পর্যন্ত আপনাদের Centre-এ ভর্তি ছিল, 9/5/21 Patient Release-র সময় শ্রী ভজন ঘোষ আপনাদের Centre পাওনা 19324/- (Nineteen thousand three hundred twenty four) only জমা দেন, সমস্ত documents চেয়ে পাঠান, শ্রী ভজন ঘোষ Care Health Insurance Company-র কাছে উনি কে অর্থ ফেরত পাবার জন্য Claim করলে Insurance Company আপনাদের Centre-এ Treatment-র পর্যন্ত documents চেয়ে পাঠায়, শ্রী ভজন ঘোষ ঐ documents আপনাদের Centre থেকে আপনারা ঐ documents দিতে পারেন নি, এর ফলে শ্রী ভজন ঘোষ Insurance Company-র কাছ থেকে ঐ অর্থ ফেরত পান নি,

অতি এই আপনার কাছে অনুরোধ- অতি সত্বর আপনি উনার সমস্ত documents খুঁজে বার করুন এবং করে শ্রী ঘোষ ফেরত পান সহ্যতা আপনাদের সংস্থার থেকে ঐ অর্থ ফেরত দেবার ব্যবস্থা করুন,

ধন্যবাদান্তে -

আপনীয় -

Copy to : - ১) জেলা শাসক, পশ্চিম বর্ধমান জেলা,
২) মহকুমা শাসক, আসানসোল,

Enclosed :-
1) Photo Copy of Applicant
2) Reminder Copy (1 x 2) of Care Health Insurance Insurance claim
3) Hospital Bill.

- প্রয়োজনীয় ব্যবস্থা গ্রহনের জন্য আবেদন জানাচ্ছি,

President
West Bengal
National Human Rights & Crime Control Bureau
Regd. NATI AAYOG (Govt. of India.)
UNDESA (United Nation) Affi. to-WHRF

Mob. : +91 9470104079
+91 9933581779

To
The President
National Human Rights & Crime Control Bureau
West Bengal

মহাশয়,

আপনার নিকট বিনীত আবেদন এই যে, আমি শ্রী ভজন ঘোষ, ঠিকানা - ই.এস - ৮/২/২, কল্যাণপুর হাউজিং এস্টেট, আসানসোল - ৫ এর বাসিন্দা, আমি ও এবং আমার পরিবার Care Health Insurance এর গ্রাহক, আমার Policy NO 17340422. গত ৫/5/2021 আমার পুত্র শ্রী সুপ্রিয় ঘোষ Advanced Laparoscopic & Medical ডিসিজ - র জন্য ভর্তি হয় কারিরিক অসুস্থতা নিমিত্তে, 6/5/21 থেকে 9/5/21 পর্যন্ত ই Hospital এই আকার কারনে 19324/- টাকার বিল করে, ই অর্থ আমাকে Cash হিসাবে হসপিটালে দেওয়া হয়, পরবর্তীকালে Care Health Insurance - ই মেম্বারে আমার Policy করা আছে তাদের কাছে ই অর্থ আমি Claim করি, কিন্তু আজও পর্যন্ত ই Insurance Company আমাকে ই টাকা ফেরত দেয় নি,

তাই আপনার কাছে অনুরোধ জানাচ্ছি ই Insurance Company-র কাছ থেকে যাতে আমি ই অর্থ ফেরত পাই তার ব্যবস্থা করে দেন তাহলে আমি খুব উপকৃত হবো,

বিনয়াবনতে

বিশ্বস্ত -
Bhajan Ghosh
M.B-9064687447
Kalyanpur Housing Estate
AS-8/2/2
Asansol-5

Date - 18/04/22

Enclosed :- 1) Reminder Copy (1 & 2) of Care Health Insurance
2) Insurance claim
3) Hospital Bill

Received
Anubhab
19/4/22

UIN ID. : NHRCCB/ 0647
01 0470104679

care
HEALTH INSURANCE

Claim Form - 'CARE'

Part A

1. to be filled in by the Insured.
2. The issue of this Form is not to be taken as an admission of liability.
3. To be filled in block letters.

Claim Intimation No: _____

Section A - Details of Primary Insured

a) Policy No. : 173404422

b) SL No./Certificate No: 19541085 c) Company/TPA ID No:

d) Name : GHOSH BHAJAN

e) Address : KALYANPUR HOUSING AS-8/2/2
RAMKRISHNA MISSION NEAR SUKANTA
VIDYALAY City: ASANSOL

State : WEST BENGAL Pin Code: 713341

Phone Number : 9064687447

E-mail : bhajanghosh2017asn@gmail.com

Section B - Details of Insurance History

a) Currently covered by any other Mediclaim/Health Insurance : ___ Yes ✓ No

b) Date of commencement of first insurance without break : / /

c) If yes, Company Name : _____

Policy Number : Sum Insured (Rs.): _____

d) Have you ever been hospitalized in the last 4 years since inception of the contract? Yes No

Date: / /

Diagnosis: _____

e) Previously covered by any other Mediclaim/Health Insurance: Yes ✓ No

f) If yes, Company Name: _____

Section C - Details of Insured Person Hospitalised

Title : ✓ Mr. Ms.

a) Name : GHOSH SUPRIYO

b) Gender : ✓ M ___ F c) Age: 17/03 d) Date of Birth: 09/02/2004

e) Relationship with Primary Insured : ___ Self ___ Spouse ✓ Child ___ Father ___ Mother

Others (Please Specify) _____

f) Occupation : ___ Service ___ Self Employed ___ Homemaker ___ Retired ✓ Student ___ Others (Please Specify) _____

g) Address : KALYANPUR HOUSING AS-8/2/2
RAMKRISHNA MISSION NEAR SUKANTA
VIDYALAY City: ASANSOL

State : WEST BENGAL Pin Code: 713341

h) Phone Number: 9064687447

i) E-mail : bhajanghosh2017asn@gmail.com

ection D - Details of Hospitalisation

a) Name of Hospital where Admitted : ADVANCED LAPAROSCOPIC AND MEDICAL CENTRE

b) Room Category occupied : ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☑ 3 or more beds per room

c) Hospitalisation due to : ☐ Injury ☑ Illness ☐ Maternity

d) Date of Injury/Date Disease first detected/Date of Delivery : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

e) Date of Admission : 06 / 05 / 2021 (DD/MM/YYYY) f) Time of Admission : 09 : 10

g) Date of Discharge : 09 / 05 / 2021 (DD/MM/YYYY) h) Time of Discharge : 01 : 30

i) If injury, give cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

j) If Medico Legal : ☐ Yes ☑ No ii) Reported to Police : ☐ Yes ☑ No

iii) MLC Report & Police FIR attached : ☐ Yes ☑ No j) System of Medicine : _____

Section E - Details of Claim

a) Details of the treatment expenses claimed

(i) Pre-hospitalization Expenses : Rs. ☐☐☐☐☐☐☐

(ii) Hospitalization Expenses : Rs. ☐☐☐☐☐☐☐

(iii) Post-hospitalization Expenses : Rs. ☐☐☐☐☐☐☐

(iv) Health Check-up cost : Rs. ☐☐☐☐☐☐☐

(v) Ambulance Charges : Rs. ☐☐☐☐☐☐☐

(vi) Others (code) ☐☐ : Rs. ☐☐☐☐☐☐☐

Total : Rs. ☐☐☐☐☐☐☐

(vii) Pre-hospitalization period : ☐☐☐ days

(viii) Post-hospitalization period : ☐☐☐ days

b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No

(If yes, provide details in annexure)

c) Details of Lump sum/cash benefit claimed :

(i) Hospital Daily Cash : Rs. ☐☐☐☐☐☐

(ii) Surgical Cash : Rs. ☐☐☐☐☐☐

(iii) Critical Illness Benefit : Rs. ☐☐☐☐☐☐

(iv) Convalescence : Rs. ☐☐☐☐☐☐

(v) Pre/Post hospitalization Lump sum benefit : Rs. ☐☐☐☐☐☐☐

(vi) Others ☐☐☐ : Rs. ☐☐☐☐☐☐☐

Total : Rs. ☐☐☐☐☐☐☐

d) Claim Documents Submitted - Checklist

(i)	Claim Form Duly signed	☑	(vii)	Pharmacy Bill	☑
(ii)	Copy of the claim intimation, if any	☑	(viii)	Operation Theatre Notes	☐
(iii)	Hospital Main Bill	☑	(ix)	ECG	☑
(iv)	Hospital Break-up Bill	☐	(x)	Doctor's request for investigation	☑
(v)	Hospital Bill Payment Receipt	☑	(xi)	Investigation Reports (Including CT/MRI/USG/HPE)	☐
(vi)	Hospital Discharge Summary	☑	(xii)	Doctor's Prescriptions	☑

(xiii) Others ☐ _____

Claim Form - 'CARE'

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 pre-authorization request form in lieu of PART A.
- To be filled in block letters.

Section A - Details of Hospital

a) Name of the Hospital : ALMC HOSPITAL

b) Hospital ID : NA

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

d) Name of the treating doctor : GHOSH DR SUBHODEEP

e) Qualification : MD PHYSICIAN FICM CCEBDM

f) Registration No. with State Code: 44089MCI

g) Contact No. : 9903075369

Section B - Details of the Patient Admitted

a) Name of the Patient: GHOSH SUPRIYO

b) IP Registration No. : 264

c) Gender : ☑ M ☐ F d) Age: 17/03 e) Date of Birth: 09/02/2004

f) Date of Admission : 06/05/2021 g) Time of Admission: 09:10

h) Date of Discharge : 09/05/2021 i) Time of Discharge : 01:30

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

k) If Maternity,

(i) Date of Delivery : / / (ii) Gravida Status : _____

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

m) Total Claimed Amount : 19,324/=

Section C - Details of Ailment Diagnosed (Primary)

a) (i) Primary Diagnosis : ICD 10 Code : Description : _____

(ii) Additional Diagnosis : ICD 10 Code : Description : _____

(iii) Co-morbidities : ICD 10 Code : Description : _____

(iv) Co-morbidities : ICD 10 Code : Description : _____

b) (i) Procedure 1 : ICD 10 Code : Description : _____

(ii) Procedure 2 : ICD 10 Code : Description : _____

(iii) Procedure 3 : ICD 10 Code : Description : _____

(iv) Details of Procedure : _____

c) Present ailment is a complication of PED : ☐ Yes ☐ No

If yes, specify details : _____

d) Pre-authorization obtained : ☐ Yes ☐ No

e) Pre-authorization no. :

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

_____

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 - Checklist

(i)	Duly signed Claim Form	: ✓	(ix)	Investigation Report	: ✓
(ii)	Original Pre-authorization request	:	(x)	CT/MRI/USG/HPE investigation reports	:
(iii)	Copy of Pre-authorization approval letter	:	(xi)	Doctor's reference slip for investigation	: ✓
(iv)	Copy of photo ID card of patient verified by hospital	:	(xii)	ECG	:
(v)	Hospital Discharge Summary	:	(xiii)	Pharmacy Bills	: ✓
(vi)	Operation Theatre notes	:	(xiv)	MLC report & Police FIR	:
(vii)	Hospital Main Bill	: ✓	(xv)	Original death summary from hospital where applicable	:
(viii)	Hospital Break-up Bill	:	(xvi)	Any other, please specify_____	:

Section E - Additional Details in case of Non-Network Hospital (Only fill in case of non-network hospital)

a) Address of the Hospital : ADVANCED LAPAROSCOPIC AND MEDICAL CENTRE SENGELEIS II OPP. SPENCERS ASANSOL

City : ASANSOL

State : WEST BENGAL Pin Code: 713305

Contact No. : 0341--2255225---

c) Registration No. with State Code : 34819687----

d) Hospital PAN : ABEFA6340G

e) No. of inpatient beds: 20--

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

(iii) Others: Afe & New Afe Cabins, Male & Female wards

Section F - 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 facts, our right to claim under this claim shall be forfeited.

Date : 26/05/2021

Place : Asansol

Signature & Seal : Ravinder Singh

ADVANCED LAPAROSCOPIC & MEDICAL CENTRE ASANSOL-713305

ction F - Details of Bills Enclosed

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1	446	09/05/2021	HOSPITAL	Hospital Main Bill	9,900/=
2		(DD/MM/YYYY)		Pre-hospitalization Bills: ___Nos	
3		(DD/MM/YYYY)		Post-hospitalization Bills: ___Nos	
4	869	06/05/2021	PHARMACY	Pharmacy bills	7,751/=
	919	08/05/2021	PHARMACY		1,673/=
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)		Total Rs →	19324/=

In case of more details, please attach a separate sheet.

Section G - Details of Primary Insured's Bank Account

a) PAN : AKDPG5130A

b) Account Number : 42040201000806 11

c) Bank Name & Branch : UNION BANK OF INDIA ASANSOL

d) Cheque/DD payable details :

e) IFSC Code : UBIN0542041

Section H - Declaration by the Insured

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 with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/Company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended or 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 : 27/05/2021 (DD/MM/YYYY)

Signature of the Insured : Brajam Ghosh

Place : Asansol

ALMC ADVANCED LAPAROSCOPIC AND MEDICAL CENTRE

SEN-RELEIGH ROAD, ASANSOL - 713305, Ph.: 0341-2255225

MEDICINE REQUISITION / INVESTIGATION

Name : Supriya Ghosh **Date** 06/5/21

ID No.: 264 **Age :** 12y **Sex :** m

Under Doctor : Dr. S. Ghosh

MW 04

Conservative

1) ~~Monotrack (1gm)~~ - 6

~~Tab. Ciprox (400)~~ - 10.

2) ~~Pan 40~~ - 5

3) ~~Inj~~ - 6

4) ~~Pimba (400)~~ - ~~3~~

~~Inj~~ Sucrafil 'O' - (1) ph.

NS (100) - 6

NS (500) - 4

~~Dsol~~ - 2

~~Zelio (20)~~ 2

~~Dsyp~~ - 2

~~D/S 10cc~~ - 10

~~D/S 5cc~~ - 5

~~3-way~~ - 1

~~Abocath~~ Scalp - 1

Handwash - 1

Hand Gloves - 1

Signature

1. OT

2. Ward

No.- 889 Cash Memo / Bill

M/S. ALMC MEDICAL STORES

SEN-RELEIGH ROAD, ASANSOL - 713305

DL. No.- WB/BDN/BIO/R/64272 ● DL. No.- WB/BDN/NBO/R/64272

Name : Sutriya [illegible] Ghosh Age 17y Sex m

Under Dr. S. Ghosal

Address :

Item	Particulars	Batch No.	Exp. Dt.	Amount
1	[illegible]	MRK-03	9/21	4794
2	[illegible]-10	D 0014 -76	7/23	352
3	[illegible] 40-3	D 10120 -77C	10/22	147
4	[illegible] -6	EALA-05	2/23	78
5	[illegible]-3	ABW1107	7/22	447
6	Syp Sucrafil			
7	NS 100 -6	D-15 H 2046	11/23	229
8	NS - 500 - 4	206039 -01	10/23	222
9	IV set - 2	F 10204	2/23	124
10	Jelco 20 - 2	407222 -16	1/26	286
11	Easyfix - 2	ML63L -6(H)	10/25	272
12	[illegible] 10cc-10	20MA5A -8202	4/22	132
13	[illegible] 2cc -5	21A04A -8201	12/22	220
14	3 way -	G-180627 3	12/22	50
15	Sprit -1	550	5/24	153
16	Handwash	6/0412	1/23	125
17	Handcap -5			25
				125
			TOTAL	
			ADV.	/
			DUE	7751/-

Due

Date 6/5/21

Signature

ALMC ADVANCED LAPAROSCOPIC AND MEDICAL CENTRE

SEN-RELEIGH ROAD, ASANSOL - 713305, Ph.: 0341-2255225

MEDICINE REQUISITION / INVESTIGATION

Name : Subhajit Ghosh Date 08/05/24

ID No.: 264 Age : 12yr Sex : M

Under Doctor : S.G Ghosh

① Inj. Monocef (1gm) 2 Pc

② Inj. Pan. (40) 1 Pc

③ Inj. Zofer 2Pc

④ Inj. Trimi 6 (400) 1 Pc

⑤ Dil 10cc 2 Pc

⑥

Signature

1. OT

2 Ward

No.: Cash Memo / Bill

M/S. ALMC MEDICAL STORES

SEN-RELEIGH ROAD, ASANSOL - 713305

DL. No.- WB/BDN/BIO/R/64272 ● DL. No.- WB/BDN/NBO/R/64272

Name : Sylvia Ghosh Age 17 Sex F

Under Dr. Ghosh

Address :

Item	Particulars	Batch No.	Exp. Dt.	Amount
1	1 meroknick-2		9/21	1598
2	2 pan 40-1		10/22	49
3	1 ondan-		2/23	26
			9/22	
			TOTAL	1673
			ADV.	
			DUE	

Due

Date 8/5/21

Signature

Dr. Subhadeep Ghosh

MD (Physician) FICM, CCEBDM

Consultant Physician, Intsnsivisit
Critical Care Specialist, Diabetes & Thyroid

Formally attached to
SSKM (Kolkata), FORTIS (Kolkata), APOLLO (Delhi), MISSION (Durgapur)
MEMBER OF INTEGRATED DIABETES & ENDOCRINE SOCIETY (INDIA & USA)
MEMBER OF CHEST PHYSICIAN (WEST BENGAL)
ASSOCIATE MEMBER OF ECHOCARDIOGRAPHY (WBAE)

Emergency Cont.:
8927851167, 9903075369

Regd. No.: 44089 / MCI

Name : Supriyo Ghosh Age : 17 Sex : M Date : 6/5/21

BP:- 113/83
PLyt:- 92
SpO2 - 96%

Covid RT PCR

Blood culture

- admission in general ward.
- inj Piperacillin (1gm) + 1/2 e TDS
- tab Rantac (150) 1-1-1 BBF
- inj Pan (40) 0/1/0 e OD
- inj Zofer (4) 0/1/0 e TDS
- NS @ 8 hrly
- Inj Mafucraft (0) (15ml) + TDS
- inj Tinida (400) 0/1/0 e OD

MY CLINIC
Service Redefined
Sanjeevani
POLYCLINIC & DIAGNOSTIC CENTRE
Dutta Bagan, Lower Kumarpur,
Opp. Spencer, Asansol-713305

ALMC.

HEALTH INSURANCE

Reminder I

To,
Bhajan Ghosh
Kalyandur housing AS-8/2/2Ramk Near Sukanta Vidyalay Dist -PaAsansol Asansol WEST
BENGAL
[illegible]
WEST BENGAL
713341

Date : 02/Sep/2021
CL No : 91835510-00

Subject: Additional information required for claim of "Supriyo Ghosh"

Dear Sir/Madam,

In reference to our letter dated 26/Aug/2021, we are yet to receive the following documents required to process your claim (Claim No. - 91835510-00) pertaining to Health insurance policy 19541085

NEED

1. **INVESTIGATION REPORT SUPPORTING DIAGNOSIS.**
2. **ADVISE FOR ADMISSION**
3. **DOCTOR PRESCRIPTION**
4. **TREATING DOCTOR'S CERTIFICATE JUSTIFYING THE PROLONGED / NEED OF HOSPITALISATION.**
5. **PERSONALIZED CANCELLED CHEQUE IN THE NAME OF PROPOSER/PRIMARY MEMBER OR NEFT MANDATE FORM SIGNED AND STAMPED BY BANK AUTHORITIES.**
   BHAJAN GHOSH
6. **PRE HOSPITALISATION OPD TREATMENT RECORD.**
7. **COMPLETE INDOOR CASE PAPERS WITH ADMISSION NOTES, HISTORY SHEET, DOCTOR'S NOTES, NURSING NOTES AND VITAL CHART.**

Kindly send the aforementioned documents at the earliest to below mentioned address. Please note that we would be unable to process your claim till receipt of the pending documents.

For any assistance, please write to claims@careinsurance.com or visit our web site http://www.careinsurance.com

Now, check your claim status via SMS Claim (91835510-00) to 77158-77158

With warm regards .

No.: 446 **Cash Memo / Bill**

ALMC ADVANCED LAPAROSCOPIC AND MEDICAL CENTRE

SEN-RELEIGH ROAD, ASANSOL - 713305, Ph.: 0341-2256225

ID No. 264 Date 09/05/21

Name Mr Supriyo Ghosh

Address Kalyanpur Housing pe: P.K. Mission, P/Adr (W)

Consultant Doctor Dr. Subhadeep Ghosh

Date of Admission 06/05/21 aft 9:10 p.m

Date of Discharge 09/05/21 aft 1:00 p.m

		Rs.	P
Bed Charges	Bed charges	3300	:00
O.T. Charges	R/O —	900	:00
L.R. Charges	Attended at —	900	:00
Gas Charges (Oxygen)	Dr. Subhadeep Ghosh —	4,800	:00
Dressing Charges	—		
Procedure Charges (Emergency)	—		
B.T Charges	—		
ECG	—		
RMO	—		
ABG Analyser	—		
C-ARM	—		
Nebulizer	—		
Other Charges	—		
	TOTAL	9,900	:00

∴ Nine Thousand Nine hundred only

Bhaijan Ghosh

Authorized Signatory

ALMC ADVANCED LAPAROSCOPIC AND MEDICAL CENTRE
Advanced Technology - Better Care

SEN-RELEIGH ROAD, (OPP. ASANSOL SPENCERS) ASANSOL-713305, Ph.: 0341-2255225

320

DISCHARGE CERTIFICATE

Patient's Name Subroto Ghosh Age 17 yr Sex M

Address Kalyanpur housing P.O R.K.Mission. PS Asansol (North)

Patient ID No. 264 Doctor Incharge Dr. S. Ghosh,

Adm. Date & Time 06/05/21 at 9:10 Pm Discharge Date 09/05/21 at 1:30 Pm

Ward / Bed C/M/W Bed NO. 04 Date of Operation N/A

Treatment Given :

Conservative

Final Diagnosis :

AGR

Covid (-ve)

Advice :

- Tab Pyrigesic (650) 1 T QDS x 5d
- Tab Bro T (100) 1 T BDPC x 10d
- Tab Dilectine (12) 1 T BDPC x 5d
- Tab Onden (4) 1 T TDAC x 10d
- Home quarantine 2 wks

- Tab Merosure O (200) 1 T BDPC x 5d
- Tab Tmobe (500) 1 T BDPC x 5d
- Tab Rexfax (400) 1 T BDPC x 10d
- Syr Sucrafil O (15ml) x TDS x 7d & SOS
- Tab Veloz D 1 T ODAC
- Cap VSL 3 1 cap BDPC x 10d

Signature of
Consultant / RMO

24 HRS. EMERGENCY

Consent Letter

Date

To,

The Medical Superintendent

_____

_____

_____

Dear Sir,

Re : Authorization in favour of M/s Care Health Insurance Limited and its authorized agents.

I have undergone treatment for

ADVANCED LAPAROSCOPIC AND MEDICAL CENTRE

06-05-2021 from 09-05-2021 to _____ in your hospital under Inpatient No 264.

I hereby authorise M/s Care Health Insurance Limited and/or its authorised representative to seek any medical information / records from you or fro
Medical Practitioners who has attended on me in connection with the above ailment.

I have no objection in case they seek such information/records in whatsoever regards.

Thanking You.

Yours Faithfully

(Signature of the Claimant)

Address of the Insured -