COST ESTIMATE

Date	: 30-Nov-23	**Dept**	: ADMISSION OFFICE
Prepared By	: SANLENDRA GUNGAH	**Reference**	: SG/IPD/SK/1123/000
UHID	: C0468485	**Date of Birth**	: 29 YEARS
Patient Name	: MR JEAN YOAN MERVIN CHETTE	**Telephone No.**	: 55165136
Patient Address	:	**Email Address**	:
Surgery/Diagnosis	: CERVICAL DISC REPLACEMENT 2 LEVEL	**Class of Surgery**	: **CLASS 9**
Doctor's Name	: DR S KARUNAGARAN	**Surgery Time:**	:

Service Name	Unit	Cost per unit (Mur)	Total Cost (Mur)
Doctor Fee			
Surgeon fee			200,000
Anesthetist fee	2,050	19.5	39,975
Operation Theatre			
OT Charges Class 9			31,890
OT Consumables/Pharmacy			320,000
Equipment: C arm/light source			14,330
Ward			
Private Ward	3	8,300	24,900
Medical administration/Physiotherapy			5,200
Ward Consumables/Pharmacy			10,000
Investigations: Blood test/X ray			13,000
Above Cost estimate excludes any additional stay, investigation, consignment, medical or surgical complications, medical referral and treatment not related to the above condition			
Estimated Cost of Treatment			**659,295**

Please note that:

A down payment of 100% of the cost estimate is required at time of admission.

In case additional cost not included in the above estimate arises, further payments will be requested from the patient/responsible party.

In case the patient is covered partly by an insurance company, the excess (i.e. the amount for the service rendered, which is not covered by the insurance) shall be immediately due and demandable and the patient/responsible party unequivocally undertakes to pay the said excess.

In the event, the claim is declined by the insurance company, the total cost shall be paid by the said patient/ responsible party declares having the required means and/or funds to pay the said total cost.

In the unlikely event that the deposit paid is more than the bill, refund will be made with 14 days post discharge.

Patient above 60 years of age needs to provide the National Identity Card for blood exemption fee at the time of blood request.

Important Note:

The estimate is only an indication of the cost of a typical treatment/ surgery.

In case of complication, a re-assement will be made on the above cost estimate and you will be Informed accordingly.

For any inquiry about the Cost Estimate, Please call on 6051019 or 605-1000 (Extension 2711/2969/2811)

Quotation is subject to price change. Management reserves the right in this jurisdiction

I , the undersigned, hereby agree that the content and the clauses of the cost estimate have been explained to me clearly and I am fully satisfied with the information provided. I also agree for Wellkin Hospital to send my medical report and the cost estimate to my insurance company for a guarantee of payment, if applicable.

Patient/Next of Kin Signature : _____ **Date :** _____

Prepared By: SANLENDRA GUNGAH 30-Nov-23

This Estimate is valid for 30 days

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