COST ESTIMATE

Date issuec 13/09/2024

Prepared by	JENITA HEERAUMUN	**Cost estimate #**	JEN/PACS/0924
Contact #	605 1019	**Valid for**	30 DAYS
UHID	C0511467	**Age/Sex**	53 YRS FEMALE
Patient name	Mrs MARJORIE ANICK CALOU	**Contact #**	58282635
DOB	10/02/1971	**NIC / Passport #**	M100271130226D
Address	FOUNTAIN STREET MARE LA CHAUX	**E-mail**	
Panel name	CASH	**Panel type**	CASH
Panel e-mail			

Dear MRS CALOU

Thank you for considering C-Care Wellkin as your trusted healthcare partner. We are committed to delivering high-quality care.
We are pleased to offer our best proposal for your upcoming treatment.

Surgery name	MEDICAL TREATMENT	**Surgery class**	
Doctor	DR F AUMEER	**Surgery date/time**	
Length of stay/days	3 DAYS STAY		

Description/Particulars	Units	Rate (MUR)	Discount (MUR)	Amount (MUR)
Interim Bill as from 13.09.2024@ 15hrs20 Pm excluding payment (Rs 209000)				**393,848**
Doctor Fee				-
Surgeon fee: Dr Aumeer.	900	19.5		17,550
				-
Ward				-
ICU	3	14,450		43,350
Medical administration/Physiotherapy				8,000
Ward Consumables /Pharmacy				70,000
Investigation: Routine blood test				10,000
Blood transfusion: if packed cell transfused will be charged RS 3350 per unit used				-
Above Cost estimate excludes any additional stay, medical or surgical complications, medical referral , blood transfusion and treatment not related to the above condition				-
				-
				-
				-
				-
				-
	Total amount (MUR)			**542,748**
	Total item discount (MUR)			-
	Cost estimate discount (MUR)			
	Total estimated cost of treatment (EUR)			

Notes:

DISCLAIMER FOR COST ESTIMATE

- This cost estimate provides a general indication of treatment expenses, subject to variations based on the patient's medical condition, treatment nuances, potential complications, admission specifics, room type, and additional medical requirements.
- Upon admission, a 100% down payment is required, as per the C-Care Policy. Any additional charges exceeding the estimate will be communicated during the patient's stay.
- For insurance patients, it is the responsibility of the patient/guardian/legal administrator/Next of Kin to confirm the level of coverage with the insurance company. The patient/representative commits to settling any uncovered amounts when due.
- Upon discharge, the remaining balance, as detailed in the final invoice, must be settled in full. Refunds, if applicable, will be processed within 10 working days after the bill closure, should the final amount be less than the deposit.
- The provided quotation is valid for 30 days from the date of issue and management reserves the right for any price adjustments.

Other remarks:
N/A

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 that C-Care Wellkin Hospital sends my medical report and my cost estimate to my insurance company for a guarantee of payment, if applicable.

Patient/Next of Kin Signature: ---------- Date: ----------

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