CLAIM FORM

SAFEWAY TPA SERVICE PVT.LTD.
815, Vishwa Sadan, District Centre , Janak Puri, New Delhi – 11 0058
Tel : 011-45451300 Fax :011-41425672/912266466797
Email-support@safewaymediclaim.com

Name of the Insurance Company: ____________________________________ Policy No.: _______________________

Safeway Id. Card no.:_________________ Nature of illness____

Name of the Claimant ____

Address: ____

Contact No:________________________________ E-mail ____

Name of the patient: __________________________Relation with Claimant______________ Age: ____Sex: M / F ____

Date of injury sustained or Disease first detected: DD/MM/YYYY____

Hospital Name and address: ____________________________Regd. No. : _____________ No. of Beds _____________

Name and Address of attending Doctor:____________________________________ Regd. No. __________________

Admitted on : Date ______________ Time ________________ Discharged on: Date _______________ Time ___________

IPD No. / File No.____________ Room No ________ Type of Room ____________________

Total Amount Claimed: Rs.____

Whether Cashless Facility / claim availed earlier, if yes please provide details:____________________________________

Previous coverage details, if any:____

I HAVE 'NO OBJECTION' IN SAFEWAY MEDICLAIM SERVICES PVT LTD. OBTAINING DETAILS OF MY TREATMENT / COLLECTING DOCUMENTS AND / OR VERIFYING HOSPITAL RECORDS. (THIS MAY BE TREATED AS MY CONSENT FOR 1VERIFICATION OF HOSPITAL RECORDS CONCERNING MY ADMISSION)

I HEREBY WARRANT THE TRUTH OF THE FOREGOING PARTICULARS IN EVERY RESPECT AND I AGREE THAT IF I HAVE MADE OR SHALL MAKE ANY FALSE OR UNTRUE STATEMENT, SUPPRESS OR CONCEAL ANY MATERIAL FACT, THEN, MY RIGHT TO CLAIM REIMBURSEMENT OF THE SAID EXPENSES WOULD STAND FORFEITED. I FURTHER DECLARE THAT IN RESPECT OF THE ABOVE TREATMENT, NO BENEFITS ARE ADMISSIBLE UNDER ANY OTHER MEDICAL SCHEME OR INSURANCE.

Signature (Insured / Claimant)

In support of the above claim, Please enclose the following documents, **in original: -**

- Copy of ID Card.
- Completely filled and signed claim form.
- Original detailed Discharge Summary
- Final bill of the hospital and the payment receipts in original.
- Package Break-up details, (if applicable)
- All the investigation reports in original.
- All the medicine purchase vouchers with supporting prescriptions in original.
- Record of treatment taken in Pre & post hospitalization periods, if any.
- Hospital Registration Certificate with local Government authorities.
- Copy of Authorization Letter

INSURED'S BANK DETAIL

BENEFICARY:____

ACCOUNT NO:____

IFSC CODE :____

BANK NAME:____

BANK BRANCH:____

CITY____

NOTE : DETAIL TO BE FILLED IN RESPECT OF HOLDER/CUSTOMER