SAFEWAY TPA SERVICE PVT.LTD.
6/2, Industrial Area Kirti Nagar Near SBI Bank New Delhi-15,
Tel : 011-41425671/72 ,2511464823, Fax :011-41425672/912266466797
Email-support@safewaymediclaim.com

ADMISSION REQUEST NOTE

PART A- TO BE FILLED IN BY TREATING CONSULTANT

Date_____

Name: Mr./Mrs: _____ Age: _____yrs. Sex _____

SMS I.D. No:_____ Corporate Name/ Emp Code_____

Name of Treating Doctor_____ Doctor's Tel No:_____

Hospital / Nursing Home:_____ _____Fax No/Tel.No _____

First Doctor Consulted :_____Date:_____

Present Complaints:_____

History of Present complaints_____

Duration of Present complaints:_____

Relevant Clinical Findings:_____

Relevant past history & treatment:_____

Provisional/Differential Diagnosis:_____

Line of treatment (Medical/Surgical)_____

Proposed Treatment Plan (attach separate sheet):_____

Is the patient suffering from: (If yes, Since When)

Particulars	Yes/No	Since When	
Hypertension			
IHD			
Osteoarthritis			
COPD/Bronchial Asthama			
Any other Chronic Disorder			

Particulars	Yes/No	Since When
Diabetes		
Heart Diseases(Date of episode)		
Cancer		
Alcohol/Drug abuse		
Maternity cases: Gravida__Para	_Living_	LMP

In c/o Accident,influence of alcohol / any other drugs:**Yes/No** **(Kindly Fax MLC)**

Particulars	Details
Date of admission	
Approximate expenses	
Room Rent	
Investigation Charges	

Particulars	Details
Approximate duration of stay	
Class of accommodation	
Doctor / Surgeon Fees/ OT Charges/ Medicines	
Package Rate	
Total Amount	

PART B - TO BE FILLED BY THE HOSPITAL AUTHORITIES

Safeway Mediclaim will not be held liable for the payment in the event of any discrepancy between the facts presented at the time of admission & in final documents submission.

Signature & Stamp of Treating Doctor:_____ **Rubber Stamp of Hospital & Signature**_____

PART C- TO BE FILLED UP BY THE INSURED

I have 'No Objection' to Safeway Mediclaim obtaining details of my treatment / collecting documents and also hereby authorize SMS to pay the hospital bill & reimburse itself / receive the amount from my claim receivable from my insurance company . If my claim is rejected, I/we (the patient) will pay for the hospital & related expenses should this authorization become null & void due to wrong and/ or misleading and/or incorrect information regarding the duration of ailments and/or
Other historical information regarding my (patients) health status/. I acknowledge and agree that information provided by me are true and up to the best of my knowledge.

Previous policy details – Policy No._____ Insurance Company: _____
Previous claim details… Ailment_____ Date_____ Amount_____
Concurrent Policy details:_____Contact Info:_____
SIGNATURE/S.:_____Name:_____