



SAFEWAY MEDICLAIM SERVICE PVT.LTD.
6/2, Industrial Area Kirti Nagar Near SBI Bank New Delhi-15,
Tel : 011-41425671 25114822,25464823, Fax :011-41425672/912266466797
Email-support@safewaymediclaim.com

ADDITIONAL INFORMATION REQUEST FORM

Date: _____

To _____

CID NO. _____

We are in receipt of your requisition for Preauthorization, for the treatment of Mr/Mrs _____
_____ in _____

From the information, which we have received, it indicates that the patient is getting admitted for _____

To ascertain whether the above treatment / hospitalization would be covered under the health insurance plan of the beneficiary; we would require the following information from the Insured person/Treating doctor or the Family physician.

- First consultation letter from the doctor, for the treatment of the said ailment or for any other diseases related to the present ailment.
 - Relevant History regarding the Origin, duration and progress of the presenting complaints.
 - Past relevant and significant Medical/Surgical details.
 - Findings of investigations, if done.
 - Duration of Diabetes/Hypertension/IHD in particular with details of treatment for the same.
 - Any other.
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The above information will help us to confirm the coverage of the insured person with the respective health insurance benefit plan.

We request you to submit the above information at the earliest to avail the cashless benefit.

Authorized Signatory of SMS

** Disclaimer: TPA can pre-authorize cashless treatment subject to terms and condition of the policy, based on adequate, relevant medical information. However the patient is advised to continue / follow his / her treatment as advised by the attending doctor and not discontinue the same for pre authorization.