



**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: \_\_\_\_\_