

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

Authorization letter to the Hospital for treatment and gurantee of payment Valid within 15 days from date of issuance of letter.

To,

	CID NO	PL NO		DOA
	(Please quote this CID in all future correspondence)			

WE HEREBY AUTHORIZE YOU TO ADMIT THE FOLLOWING PATIENT:

NAME OF THE PATIENT: _____ SAFEWAY MEDICLAIM ID NO: _____

NATURE OF ILLNESS: _____ NAME OF THE TREATING DOCTOR: _____

GUARANTEED PAYMENT UP TO RUPEES: _____ (IN WORDS) _____

APPROVED MAXIMUM LENGTH OF STAY (LOS) (DAYS) _____ CLASS OF ACCOMODATION _____

NOTE:

- If the hospital bill is estimated to be higher than the guarantee of payment, and or LOS will be longer than authorized request letter for additional amount and/or days needs to be sent to Safeway Mediclaim for review.
- If no further guarantee is available, the hospital must collect the excess amount directly from the beneficiary at the time of admission / prior to Discharge from the Hospital, as per Hospital Rules and Regulations.
- Please ensure to collect _____ % of the final bill/ approved amount from the patient.
- Charges for the following miscellaneous services and related or allied services must be collected, directly form the patient.
 - A) Telephone / Fax / Barber charges, Toiletries
 - B) Food & Beverages / Accommodation charges for the relatives
 - C) Special diet for patient charged separately
 - D) Dental Treatment if not pertaining to the ailment
 - E) Charges for photocopies
 - F) External Implants, Supports and Accessories such as Crutches, spectacles,etc.(Unless authorized)
 - G) Transport to Hospital / Home.(Unless authorized)
 - H) Baby charges in maternity cases (Unless authorized)
 - I) Vaccinations
 - J) Registration / Admission / Documentation charges
- Please send the following within 7 days of discharge of the beneficiary:
 - Hospital bill summary along with final bill showing details of units of each service.(Authenticated by the patient's signature)
 - Detailed Discharge summary / card and reports of all investigation (Original), prescription of medicines and the insurance claim form of _____ signed by the Patient / Beneficiary.

Special Remarks:

Authorized signatory _____ Stamp _____ AL No: _____ Date: _____

Please Note that hospitalization for treatment of following condition is not payable:

- 1) Convalescence, General Debility, ' Run down ' condition, rest cure, congenital external diseases, sterility, STD, intentional self-injury and use of alcohol/intoxicating drugs.
- 2) Any conditions directly or indirectly caused to or Associated with a Syndrome or condition commonly referred to as AIDS.

Disclaimer : The cashless access in SMS network of hospitals is merely a facility extended by your health coverage payer. Safeway Mediclaim / Payer does not guarantee the availability, quality and outcome of the treatment. Choosing of a network or a non-network hospital is a prerogative of the beneficiary.

Undertaking by Patient

I authorize The hospital / provider to submit the original discharge card, and all original documents related to my treatment to Safeway Mediclaim which will ensure a timely payment to the hospital.

Signature of the Patient / Beneficiary