CASHLESS REQUEST FORM

E-MEDITEK SOLUTIONS LIMITED. (IRDA License No. 007) **Date:**
45 Nathupura Road, Gurgaon.Tel: 0124 – 5062068-5062070. Fax: 0124 – 5062071. E-Mail : info@emeditek.com

PART A- TO BE FILLED IN BY TREATING CONSULTANT

Name of the Insured: Shri/Smt/Kum: _____Age: ____yrs

I. D. No (As mentioned on the ID card)_____ E-Mail ID :_____

Contact No. of insured: Landline _____ Mobile : _____

Advised admission / admitted under Dr. _____ _____

Hospital / Nursing Home _____

Date of First consultation _____

Name of the Doctor 1st consulted _____ Tel:_____

Presenting complaints:_____ _____

_____

History of Presenting complaints: _____

Relevant Clinical Findings: _____

Investigation Reports (if any): _____

Relevant past history:_____

Diagnosis: _____

Proposed Line of Treatment: _____

Details of past treatment:_____

History of the following –

Hypertension (Duration) :	Diabetes (Duration) :
IHD (Date of First episode):	Asthma and Any other :
In c/o Road Traffic Accidents, please mention if the patient was under the influence of alcohol / any other drugs Yes/No	
Obstetric History :	

SIGNATURE OF THE ATTENDING DOCTOR

PART – B – TO BE FILLED BY HOSPITAL / NURSING HOME

Proposed Date of Admission		**Total Estimated Expenses (give approximate break up as under)**	**Rs**
Approx Duration of stay		Room Charges	
Class of accommodation		Operation charges	
Name of the treating Dr., contact telephone and registration no		Investigations and medicines	
		Others	

SIGN & STAMP OF THE HOSPITAL / NURSING HOME

PART C- TO BE FILLED UP BY THE INSURED

INSURED CONSENT / AUTHORISATION

I have 'No Objection' to EMSL obtaining details of my treatment / collecting documents and also hereby authorize EMSL to pay the hospital bill & reimburse itself / receive the amount from my claim receivable from my insurance company. If my claim is rejected, I hereby undertake to pay EMSL the amount paid by them to the hospital. This consent is also final discharge for Hospitalisation part of the claim where it has affected the payment. I reserve the right to submit pre / post hospitalisation or other claims separately as and when required and as per the policy terms and conditions.

Previous policy details –Policy No._____ Insurance Company: _____
Policy period_____Sum Insured_____
Previous claim details Ailment: _____Date: _____Amount_____
Concurrent Policy Details (IF Any)- If you are holding other health Insurance policy than please furnish following information.
Name of the insurance Company:
Divisional Office address and contact no.

Policy Period: From To Policy since how many years Sum Insured:

SIGNATURE/S. OF INSURED: _____ NAME:_____