



SAFEWAY MEDICLAIM 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			

In c/o Accident, influence of alcohol / any other drugs: **Yes/No**

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

(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: _____