CLAIM FORM

SAFEWAY TPA SERVICE PVT.LTD.
815, Vishwa Sadan, District Centre , Janak Puri, New Delhi – 11 0058
Tel : 011-45451300 Fax :011-41425672/912266466797
Email-support@safewaymediclaim.com

Name of the Insurance Company: _____ Policy No.: _____

Safeway Id. Card no.:_____ Nature of illness_____

Name of the Claimant _____

Address: _____

Contact No:_____ E-mail _____

Name of the patient: _____Relation with Claimant_____ Age: ____Sex: M / F ____

Date of injury sustained or Disease first detected: DD/MM/YYYY_____

Hospital Name and address: _____Regd. No. : _____ No. of Beds _____

Name and Address of attending Doctor:_____ Regd. No. _____

Admitted on : Date _____ Time _____ Discharged on: Date _____ Time _____

IPD No. / File No._____ Room No _____ Type of Room _____

Total Amount Claimed: Rs._____

Whether Cashless Facility / claim availed earlier, if yes please provide details:_____

Previous coverage details, if any:_____

I HAVE 'NO OBJECTION' IN SAFEWAY MEDICLAIM SERVICES PVT LTD. OBTAINING DETAILS OF MY TREATMENT / COLLECTING DOCUMENTS AND / OR VERIFYING HOSPITAL RECORDS. (THIS MAY BE TREATED AS MY CONSENT FOR 1VERIFICATION OF HOSPITAL RECORDS CONCERNING MY ADMISSION)

I HEREBY WARRANT THE TRUTH OF THE FOREGOING PARTICULARS IN EVERY RESPECT AND I AGREE THAT IF I HAVE MADE OR SHALL MAKE ANY FALSE OR UNTRUE STATEMENT, SUPPRESS OR CONCEAL ANY MATERIAL FACT, THEN, MY RIGHT TO CLAIM REIMBURSEMENT OF THE SAID EXPENSES WOULD STAND FORFEITED. I FURTHER DECLARE THAT IN RESPECT OF THE ABOVE TREATMENT, NO BENEFITS ARE ADMISSIBLE UNDER ANY OTHER MEDICAL SCHEME OR INSURANCE.

Signature (Insured / Claimant)

In support of the above claim, Please enclose the following documents, **in original: -**

Copy of ID Card.
Completely filled and signed claim form.
Original detailed Discharge Summary
Final bill of the hospital and the payment receipts in original.
Package Break-up details, (if applicable)
All the investigation reports in original.
All the medicine purchase vouchers with supporting prescriptions in original.
Record of treatment taken in Pre & post hospitalization periods, if any.
Hospital Registration Certificate with local Government authorities.
Copy of Authorization Letter

INSURED'S BANK DETAIL

BENEFICARY:_____

ACCOUNT NO:_____

IFSC CODE :_____

BANK NAME:_____

BANK BRANCH:_____

CITY_____

NOTE : DETAIL TO BE FILLED IN RESPECT OF HOLDER/CUSTOMER