

**CASHLESS REQUEST FORM**

E-MEDITEK SOLUTIONS LIMITED. (IRDA License No. 007) Date: \_\_\_\_\_  
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**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 G C Gupta Hospital, 372-373, HUDA, Sec-11, Panipat(132103)  
 Date of First consultation \_\_\_\_\_  
 Name of the Doctor 1<sup>st</sup> 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 / AUTHORIZATION**

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