AUTHORIZATION REQUEST

To Be Faxed or E-Mail By The Hospital To

East West Assist Pvt. Ltd.

97 Manekshaw Road , Sainik Farms, New Delhi-62

Ph: 011-29554348, 49, Fax No: 011- 29554130 Toll Free: 1600111146

E-mail: assistance@eastwestassist.com

Insufficient Information may cause delay **To be filled by the Hospital**

Dear Sir / Madam,

This is to inform you that the patient mentioned here below has produced photo -ID Card of your organization. Please let us have your authorization.

1 Name of the Hospital………………… City……………….. Room No……….

2 Card ID No………………………………….. 3.Policy No. ……………………………….

4 Name of the Patient……………………….. 5. Age / Sex ………… Ph:……………..

6 **Admitted** Under Doctor : Dr…………………………………….. Ph:…………………

7 Presenting complaint with duration:…………………………………………………………

8 Personal History:……………………………… 9.Probable date of Admission:……………

10 Past history with duration:…………………………………………………………..

11 Relevant physical findings:………………………………………………………….

12 Indications for Hospitalization:……………………………………………………..

13 Provisional Diagnosis:……………………………………………………………….

14 Proposed Line of treatment:…………………………………………………………..

15 Approx. Expenses:

a) Surgeon's fee / Doctor's fee:	
b) Room Rent:	
c) ICU charges:	
d) Diagnostic tests:	
e) Implant:	
f) Any other Expenses /Package:	
Total:	

16 Duration of stay in the Hospital:……………………………………………………………

Any Disparity in the request & Discharge Summary is the liability of the Hospital.

Name & signature of the Doctor
Contact No.

Disclaimer

(To be completed by the patient/Insured)

1 Duration of previous Policy:………………………………………………………………

2 Detail of Previous Claim:……………………………………………………………………

I solemnly declare that the information provided by me is true & correct to the best of my knowledge. In case my claim is rejected, I hereby undertake to pay **East West Assist Pvt. Ltd.** The expense, they have paid for my hospitalization. I hereby authorize the hospital to release my medical record to **East West Assist Pvt. Ltd.** for the purpose of verification authorization / settlement of my claim.

Name & Signature of the Patient
Tel.No.: