APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES TOWARDS OUT-PATIENT CONSULTATION UNDER ALLOPATHIC SYSTEM OF MEDICINES

(Applicable for all CHSS beneficiaries including retired)

1 a.	Name of the Applicant (Capital Letters)					
b.	CHSS Card No.					
c.	Card Valid upto					
2 a.	**Employment Details:** Employee's name / Designation					
b.	ICNo./Employee Number					
c.	Unit / Place					
3.	Residential Address			Phone No.		
4 a.	Name of the Patient					
b.	Date of birth / Age					
c.	Relationship to employee					
d.	CHSS Card No.					
e.	Card Validity					
f.	Place at which patient fell ill					
5 a	Name of AMA / Doctor consulted					
b.	Number of consultation					
c.	Date(s) of consultation					
d.	Fees paid for consultation	Rs.				
6.	Details of bills enclosed and Medicines purchased :-					

S. No.	Bill No.	Date	Name of the Medicine/Test	Qty.	Amount Rs. P.
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11			Consultation fees paid if any		
			TOTAL AMOUNT CLAIMED Rs.		

List of Enclosures	Cash Bill(s)	√	Certificate `A'	√	Prescription	√

Note: Incomplete application shall not be considered. A copy of 'Drug Card' is to be attached for regular medicines reimbursement

DECLARATION TO BE SIGNED BY THE CLAIMANT

I hereby declare that the statements in this application are true to the best of my knowledge and belief and that person to whom medical expenses were incurred is wholly dependent upon me.

Date : Signature of the Claimant _____

To

APO(CHSS), DAE Hospital, Kalpakkam 603102 / DAE Clinic, Chennai

ESSENTIALITY CERTIFICATE `A'

(To be furnished in the case of out-patient treatment availed)

Certificate granted to _____

CHSS Card No._____

I, Dr. _____ hereby certify:-

a. that I charged and received Rs. _____ for _____consultation(s) on _____[date(s) to be given] at my consulting room/ Clinic/Hospital/at the residence of the patient

b. that the above mentioned patient was under my treatment and medicine(s) prescribed by me were essential for recovery of the patient. The medicines prescribed to the patient do not include any proprietary preparations for which cheaper substitutes are available or which are not primarily food / toiletry / cosmetic /disinfectant items.

c. that the patient is / was suffering from _____ and is / was under my treatment from _____to _____ .

S.No.	Bill Number	Bill Date	Amount claimed	Details(Medicines/Tests)

Date: Signature of Doctor _____

Name: (Dr.)

Clinic address: [Reg. No.] & Seal

PRE – RECEIPT

Received an amount of Rs._____/- from Pay & Accounts Officer, _____ towards Medical Reimbursement claim charges.

Signature _____

(Name:)

PAYMENT TO BE MADE AS PER THE BANK DETAILS GIVEN BELOW:-

NAME OF ACCOUNT HOLDER : _____

BANK ACCOUNT No. : _____

NAME OF THE BANK : _____

IFS Code & Place : _____