APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES

TOWARDS OUT-PATIENT TREATMENT AVAILED OUTSIDE CHSS AREA

(Applicable for CHSS beneficiaries including retired under Allopathic system of medicine)

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 or Name of Hospital with address			
b.	Number of consultation			
c.	Date(s) of consultation			
d.	Fees paid for consultation	Rs.		

6. Details of bills enclosed and Medicines purchased /Investigations if any:-

S. No.	Bill No.	Date	Name of the Medicine/Investigation	Qty.	Amount Rs. P.
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
			TOTAL AMOUNT CLAIMED Rs.		

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

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 603 102.

ESSENTIALITY CERTIFICATE `A'

(To be completed in the case of patients who are not admitted to Hospital for treatment)

Certificate granted to _____

wife/husband/son/daughter/father/mother of _____

employed in the _____

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 _____ .

Date:

Signature of Doctor
Name: (Dr.)
[Reg. No.]
& Seal

PRE – RECEIPT

Received an amount of **Rs.**_____/**-** (Rupees _____ _____ only) from Pay & Accounts Officer, _____ towards Medical Reimbursement claim.

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 : _____