LES FORM

APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES

(Medical emergency case)

1. Applicant's name: ______________________ ICNo.:______

   Designation:__________ Section:_________ Unit:_________ Ph.No.:_____

   Pay:Rs.________ Address: ______________________________

2. Whether a member of CHSS ? : Yes / No

3. Name of the patient: ______________________ CHSS No.:_________

   Relationship to employee:_____________ Date of birth: _____________

4. Reasons for not availing CHSS facility: ______________________

5. Date & place of occurrence of medical emergency : ______________________

6. Whether reported to CHSS Office within 4 days, if so to whom? : ______________________
   (If this was not done, please state the reasons)

7. Nature of treatment availed of : In-patient / Out-patient

8. Name of the Hospital & address or name/qualification/address of the Doctor from whom treatment availed of : ______________________
   ____
   Place:________________ PINCODE:

9. Details of expenses incured:
   a.Period of treatment : From ____________ To ______________
   b.Bed charges : _____________ No. of days: _______
   c.Consultation charges : _________ No. of times:_______
   d.Medicines/injections charges : _________
   e.Inj. administering charges : _________ No. of inj.: ___
   f.Lab investigation charges : _________ No. of inv.: ___
   g.X-ray charges : _________ No. of films: ___
   h.Operation charges (if any) : _________
   i.Dressing/Suturing charges : _________
   j.Other charges (if any) with details :

Total : Rs.

Date: Signature of the applicant

NOTE: Original bills/prescriptions should be enclosed with this claim

Encl.:

Treatment availed from :
(Name of the Hospital & address or
Name/qualification/address of the Doctor)

CERTIFICATE

Certified that ______________________________________ was treated in a medical emergency during the period from _________ to __________ for (illness) ____ and the clinical findings are ______________________________________. In my/our opinion but for the immediate medical aid given, there would have been, on the basis of medical and attendant consideration, a serious danger/hazard or severe or deleterious consequences to the health of the above patient. The treatment charges are as follows:

Amount
Rs. P.

a. Stay/Bed/Room charges for ____ days : _____ From _______ to ______
@ Rs. _____ per day

b. Operation charges (if any) : __________

c. Consultation/Professional charges : _____ No. of times: ______
Datewise consultation fees paid

Date	Fees

d. Lab investigation charges : _____ No. of tests: ______

e. X-ray charges : _____ No. of X-rays: _____

f. Other investigation charges(if any) with details:

g. Dressing/Suturing charges : _____ No. of dressing: ____

h. Details of medicines/injections given:

Bill No.	Date	Amount

i. Injection administering charges : ______ No. of inj.: ______

j. Other charges (if any) with details :

Total Rs.

Date:

Signature of the Doctor
(Seal)