APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES TOWARDS CONSULTATION WITH NOMINATED AUTHORISED MEDICAL ATTENDANT (AMA) / OTHER ALLOPATHIC DOCTORS

(Applicable for CHSS beneficiaries including retired)

Please tick ✓ wherever applicable *No column should be left blank*

1	a	Name of the Employee (in BLOCK LETTERS)	:
	b	IC No. / Employee Number / Desig./ Unit	:
	c	CHSS Card No. / Validity	: /
2	a	Residential Address (in BLOCK LETTERS)	Pin code: ……..
	b	Mobile Number	:
	c	Email ID	:
3	a	Name of the Patient	:
	b	Date of birth / Age	: / years
	c	Relationship to employee	:
	d	CHSS Card No. / Validity	:
	e	Place at which the patient felt ill	:
4	a	Name of the AMA / Doctor consulted	:
	b	Number of consultation (s)	:
5	Details of Expenses : **Page 2 of this form (back side)**		

DECLARATION TO BE SIGNED BY THE CLAIMANT

I hereby declare that the details 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.

Encl: Original (i) Cash bill(s) (ii) Ess. Certificate 'A' (iii) Prescription(s):

Date: Signature of the Claimant

**(Signature of spouse in case of deceased CHSS card)*

To

☐ CHSS Clinic, IMSc, C.I.T. Campus, Taramani, Chennai 600113 - Ack. No.:

☐ DAE Nodal Facility Centre, Pallavaram, Chennai 600043 - Ack. No.:

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ACKNOWLEDGEMENT SLIP

Acknowledgement No.: Received Date: Received By:

Seal

5	**Details of Expenses**							
Sl. No.	**Particulars (Consultation/Medicine /Investigation/Lab. test)**	**Bill No.**	**Date**	**Name of the (Medicine/ investigation/lab. test)**	**Qty./ Nos.**	**Claimed Amount (Rs.)**	**Eligible Amount (To be filled by CHSS)**	**Remarks**
a								
b								
c								
d								
e								
f								
g								
h								
i								
j								
					TOTAL			

ESSENTIALITY CERTIFICATE 'A'

*(**To be completed in the case of patients who are not admitted to the 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 form _____and is/was under my treatment from _____to _____.

Date: Signature of the Doctor

Name: Dr. _____
Clinic address: Reg. No. _____
…… & Seal
……
……..
Pin code: ……..

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 the Account Holder: _____
Bank Account Number: _____
Name of the bank & branch: _____
IFS Code: _____