DEPARTMENT OF ATOMIC ENERGY HOSPITAL, KALPAKKAM 603 102

INFORMATION BROCHURE ON MEDICAL FACILITIES AVAILABLE FOR RETIRED EMPLOYEES UNDER CONTRIBUTORY HEALTH SERVICES SCHEME (CHSS) OF DAE AT KALPAKKAM/CHENNAI

A) Extension of the Scheme:

Kalpakkam - Retired employees enrolled under CHSS are eligible to get CHSS facilities at Kalpakkam.

Chennai - Retired employees enrolled under CHSS and settled in Chennai are eligible for CHSS facilities at Chennai.

B) Eligibility:

- Retired employees of the Department who have put in a minimum of five years of service in the Department before their retirement and opted for the benefits of the Scheme and members of their families. (Para 2.1.10(i))

- Employees who had already retired from DAE/NPC Units in Kalpakkam/Chennai before introduction of CHSS i.e. those retired before 1.8.1993.(DAE Note No.22/10/92-CHSS/IR&W/189 dated 4.8.1994)

- Employees retired from places of DAE Units where CHSS is not available and settled down in a place where CHSS is available.(Para 2.1.10(vi))

- The benefits of the Scheme will continue to be made available to the members of the families of the retired employees who are covered by the definition of "Family" and covered under the CHSS, i.e. Spouse, dependent parents whose monthly income is less than Rs.9000/- p.m. and unmarried/unemployed children not completed 25 years of age, even after the death of retired employees subject to payment of appropriate contribution and fulfillment of other conditions.

- If life long registration is not done, it is obligatory on the part of the retired employee to revalidate the registration every year after submission of a declaration to the effect that they do not avail medical facility from any other sources. In case, the retired employees do not renew CHSS cards in time, they are not eligible for any medical treatment and reimbursement the non-renewal period. (DAE ID Note No.7/14/98/CHSS-IR&W/165 dated 19.5.1998)

- Employees should pay the contribution in advance for a minimum period of one calendar year and the contribution shall be with reference to the pay drawn by him/her prior to retirement/invalidation. Employee may also have an option to pay one time contribution for ten years to be eligible for life-long registration.

Note: If the Employee joins the Scheme after a gap on retirement, his/her last pay drawn attached to the post held by him, to be revised notionally from time to time and CHSS contribution to be calculated on the basis of pay, that would have been admissible on the date of application for life-time registration, had he/she continued in service (DAE OM No.7/8/2015/IR&W/11378 dated 29.08.2016).

- Retired employees should pay the prescribed CHSS contribution without any break from the date of retirement/registration under CHSS.

- Person who is receiving or is eligible to receive medical aid/facility/cash subsidy, cash allowance or reimbursement for medical care from any source other than this Scheme, shall not be admitted to the Scheme. (Para 4.2)

C) Application for Admission to the Scheme:

Application for registration under CHSS shall be submitted in the prescribed form (Annexure-1) forwarded by the Administration concerned with a stamp-size photo of each beneficiary to the Assistant Personnel Officer (CHSS), DAE Hospital, Kalpakkam 603 102.

In case, an employee retired from DAE Unit outside Kalpakkam/Chennai wishes to avail the CHSS facility at Kalpakkam/Chennai, he/she may submit a filled up application form alongwith a certificate issued by the concerned Unit containing following details or forward the application form through Administration of the Unit in which he/she last served:

1. Name of the retired employee :
2. Designation/Post held at the time of retirement:
3. Unit & Place from which retired:
4. Date of birth:
5. Date of joining in service (in DAE):
6. Date of retirement:
7. Whether presently covered under the CHSS: Yes / No
8. Details of family members eligible for medical facilities at the time of retirement:

Name	Date of birth	Relationship

9. Details of CHSS contribution paid if any:
   a) period upto which paid :
   b) Amount & Rate of contribution :

Retired employees of the Department who opted for the benefits of the Scheme should pay the contribution @ 1% of the basic pay last drawn per month in advance for a minimum period of one calendar year. For LIFE TIME registration, retired employees shall pay one time contribution for ten years even if he/she opts for it at a later date.

Employees retired prior to 1.1.1986, have to pay 2% of last basic pay drawn subject to maximum of Rs.30/- as monthly contribution.

Employees retired after 1.1.86 but before 1.2.98 have to pay 1% of basic pay drawn (pre-revised) subject to maximum of Rs.50/- per month.

Employees retired from 1.2.98 have to pay 1% of basic pay last drawn at the time of retirement.

Employees retired from 1.4.2004 to 31.08.2008 have to pay 1.5% of basic pay last drawn at the time of retirement (basic pay + 50% of DA as pay).

Employees who retired voluntarily with less than 25 years of qualifying service, are eligible for registration under the Scheme provided they pay an enhanced contribution at the rate of three times of the normal rate. However, the voluntarily retired employees with 30 years of qualifying service need to pay contribution at normal rate and those with less than 30 years but more than 25 years of service at double the normal rate. (DAE OM No.1/7/99/IR&W/200 dated 27.7.2000)

Payment towards CHSS contribution should be made by demand draft to be drawn in favour of "Accounts Officer, GSO" payable at State Bank of India or Canara Bank at Kalpakkam. Local Bank Cheque at Kalpakkam is also accepted.

D) Facilities available under CHSS:

i) At Kalpakkam:

All retired employees and their family members possessing valid CHSS cards, are eligible to avail medical facilities at DAE Hospital, Kalpakkam. They are eligible to get reimbursement for the medicines not available in the Hospital and prescribed by the DAE Hospital Doctors. They are eligible to get treatment/investigations at recognised Hospitals/Centres under CHSS based on the referral letters

issued for them including treatment under Indian System of Medicines. (**DAE OM No.7/2/2019-IR&W/14337 dated 21.11.2019).**

Retired employees and their family members, who are referred to recognised Hospitals/Centres outside Kalpakkam, will be entitled to claim travelling allowance from Kalpakkam as per rules.

ii) At Chennai:

Retired employees settled down at Chennai may avail medical treatment from one of the Authorised Medical Attendants (AMA) nominated under the CHSS in Chennai. Medicines prescribed by the AMA, should be purchased within 10 days or before the date of completion of treatment as shown in the essentiality certificate whichever is earlier.

AMAs at Chennai are authorised to refer the beneficiaries to the following recognised private Centres/Hospital in addition to Government Hospitals/Centres at Chennai, if required:

1	MEDISCAN SYSTEMS, 197, (Old No.92), Doctor Natesan Road, (Near Chennai City Centre), Mylapore, CHENNAI 600 004 (Ph. 24663232)	**Ultra sonogram tests**
2	LISTER METROPOLIS HEALTHCARE LIMITED, 3, Jagannathan Road, Nungambakkam, CHENNAI 600 034 (Ph: 42055555)	**All investigations**
3	NEUBERG EHRLICH LABORATORY PRIVATE LIMITED, 19, Masilamani Road, Royapettah, CHENNAI 600 014 (Ph: 28130514/28130460)	**All investigations**

A CHSS Clinic is functioning at Room No.G-7, Ground Floor, Main building, The Institute of Mathematical Science (IMSc), C.I.T. Campus, Taramani, Chennai 600 113 on all working days: Tuesday to Saturday (Except Second Saturday) between 10.00 hours and 14.00 hours and patients requiring any advice/consultation for medical treatment (including treatment for major ailments) may approach the Medical Officer for further treatment. (Phone: 044-22543126/22543198).

Reimbursement claims should be submitted in the prescribed form alongwith original bills/essentiality certificates (Form A) etc. duly signed by the AMAs at the CHSS Clinic, Chennai within a month of completion of treatment. Cost of items like toiletries, disinfectants, equivalent to food, appliances and similar items, are not admissible even if prescribed by the AMAs. Referral letter form to be issued by AMAs is available at CHSS Clinic, Chennai.

Treatment for purely aesthetic reasons will not be covered under the CHSS.

iii) Outside Kalpakkam/Chennai:

Retired employees have an option for claiming reimbursement following the pattern of CS(MA) Rules for the in-door medical treatment availed of by them and their family members provided he/she was a member of CHSS at the time of availing treatment. Such reimbursement shall be allowed only for the treatment availed of through the following:

a) Government hospitals and medical institutions of the local authorities such as District Hospitals, Medical Colleges, Municipal Hospitals etc.
b) Private Hospitals as recognised by the Ministry of Health & Family Welfare, New Delhi
c) Hospitals recognised under CGHS
d) Hospitals recognised by DAE for treatment under CHSS/CS(MA) Rules.
e) Hospitals recognised by the State Governments, other Central Government Departments and Public Sector Undertakings under the control of DAE.

Reimbursement of OPD charges to retired employees who stay outside CHSS area may be made at CGHS rates or actual rate, whichever is less. (DAE O.M.No.7/20/2016/IR&W/3184 dated 08.03.2021)

E) Treatment under medical emergency:

In medical emergencies, beneficiaries under the Scheme may receive, as a concessional measure, medical attendance and treatment from any private medical practitioner or hospital (where the emergency arises) and the reimbursement for such expenditure will be limited as per rules of the CHS Scheme.

For the purpose of this Scheme, the term "emergency" shall mean a situation or contingency when but for the immediate medical aid sought, there would have been, on the basis of the medical and attendant considerations, a serious danger or hazard or severe or deleterious consequence to the health of the patient. The accessibility/ availability or otherwise of the facilities under the Scheme in the context of the severity of medical emergency/ailment at the time of emergency will also be taken into consideration. The opinion of the Medical Superintendent, DAE Hospital shall be final as to what constitutes an emergency treatment, notwithstanding any medical certificate to the contrary produced from a private doctor or hospital.

DAE Hospital, Kalpakkam shall determine whether a claim should be reimbursed or not and also the extent to which the reimbursement should be allowed from the point of view of medical necessity etc., e.g.,
a) whether it was a case of medical emergency
b) whether the intimation regarding emergency was given as required
c) whether the items included in the claim were medically necessary &
d) whether the charges/prices are reasonable

The treatment when availed under medical emergency should be reported to the DAE Hospital, Kalpakkam within 4 days from the date of commencement of the treatment.

F) Categorization of retired employees under CHSS:

Category	Pay as per Third Pay Commission (upto Dec.1985)	Pay as per Fourth Pay Commission (Jan.1986 to Dec.1995)	Pay as per Fifth Pay Commission (From Jan.1996)
A	Upto Rs.400	Upto Rs.1350	Upto Rs.4590
B	Rs.400 to 800	Rs.1351 to 2360	Rs.4591 to 7999
C	Rs.801 to 1500	Rs.2361 to 3500	Rs.8000 to 11500
D	Rs.1501 & above	Rs.3501 & above	Rs.11501 & above

DAE vide their Note No.7/8/2009-IR&W dated 26.03.2010 have reclassified the entitlement of Hospital accommodation at Panel Hospitals recognized under CHSS as follows:

S.No.	Category of Employees (as per revised pay w.e.f. 01.01.2006)	Equivalent for employees retired prior to 01.01.2006	Class of Accommodation
1.	Employees drawing pay in the pay band of less than Rs.15000/- per month or the equivalent pay in the pre-revised scale (Grade pay not to be included)	Employees retired with basic pay in the pre-revised scale below Rs.8000/- per month (Upto Rs.2360/- for employees retired prior to 01.01.1996 and upto Rs.800/- for employees retired prior to 01.01.1986)	Four beds in a room with common toilet/bathroom
2.	Employees drawing pay in the pay band of Rs.15000/- and above but below Rs.67000/- per month or the equivalent pay in the pre-revised scale (Grade pay not to be included)	Employees retired with basic pay in the pre-revised scale of Rs.8000/- and above per month (Rs.2361/- and above for employees retired prior to 01.01.1996 and Rs.801/- and above for employees retired prior to 01.01.1986)	Two beds in a room with attached toilet/ bathroom
3.	Employees drawing pay in the pay band Rs.67000/- per month and above or equivalent pay in the pre-revised scale (Newly approved bed class)	Scientific Officers (OS) and above	Single bed AC accommodation as per availability in the referral hospital with attached toilet/ bathroom

DAE vide O.M. dated 21.07.2017, have revised the classification of entitlement of hospital accommodation for serving employees under CHS Scheme as follows:

No.	Category of employees according to pay range (as per 7 CPC pay)	Class of Accommodation
1.	Pay less than Rs.52,000/-	4 beds in a room with common toilet/bathroom (equivalent General Ward)
2.	Pay Rs.52,000/- and above but below Rs.1,72,000/-	2 beds in a room with attached toilet/bathroom (equivalent sharing room non A/c)
3.	Pay of Rs.1,72,000/- and above	Single bed AC accommodation as per availability in the referral hospital with attached toilet/bathroom

G) Annual Declaration:

For children above 18 years and parents issued with CHSS cards, an annual declaration of their dependency should be submitted to the CHSS Office, DAE Hospital, Kalpakkam 603 102 in January every year for renewing their CHSS cards. Unemployed and unmarried children are eligible for CHSS facility upto 25 years of age only. Mentally retarded/physically handicapped children shall be eligible for the benefits till such a time they are dependent on prime beneficiaries, provided that the disability exceeds 40%.

H) Contact Phone Numbers:

Medical Superintendent, DAE Hospital, Kalpakkam (044) 27481228
CHSS Office, DAE Hospital, Kalpakkam (044) 27488228
CHSS Clinic, Institute of Mathematical Sciences (IMSc),
Taramani, Chennai 600 113 (044) 22543198/
22543126

E-mail id: casualtykts@igcar.gov.in;

All correspondences relating to CHSS should be sent to:

Assistant Personnel Officer,
CHSS Office, DAE Hospital, Kalpakkam 603 102.
(E-mail: hospchss@igcar.gov.in)

All claims should be submitted alongwith a Pre-receipt (as per the format given below):

Pre-Receipt

Received an amount of Rs._____(Rupees _____) from Pay & Accounts Officer, _____ towards medical reimbursement claim.

Phone No.: _____ *Signature:_____

Address to which payment is to be sent:

Name : _____

Bank Account No.: _____ IFSC code: _____

Full address : _____

_____ Place: _____ Pincode: _____

*NOTE: Affix Re.1/- revenue stamp in case the amount claimed exceeds Rs.5000/- and sign on the stamp.

(CHSS Office use: New card No._____)

APPLICATION FORM FOR REGISTRATION UNDER CHSS BY RETIRED EMPLOYEES

1. Name of the applicant: _____ 2.Sex: M / F
   (in CAPITAL LETTERS)
3. Post last held: _____ 4.ICNo.:_____ 5.Unit:_____

6. Scale of pay of the post : Rs. _____

7. Basic pay last drawn : Rs. _____ + Grade Pay: Rs. _____

8. Date of initial appointment in DAE : _____

9. Date of retirement:_____ Superannuation/V.R.

10. Whether covered under CHSS at the time of retirement: Yes / No
    If yes, CHSS card No.: _____ Place: _____

11. Address: Present For correspondence:
    _____ _____
    _____ _____
    _____ _____
    _____Pincode:_____ _____
    Phone No. _____ Pincode: _____

12. Amount of pension received: Rs. _____
    Name of pension disbursing bank: _____
    Place: _____ Pincode:_____
    Account No.: _____

I have read the instructions on the overleaf. I fulfill the conditions prescribed for registration and request that the benefits of the Contributory Health Services Scheme of DAE at Kalpakkam/Chennai may be extended to me and to the following family member(s):

Name (CAPITAL letters)	Relation ship	Date of birth	Occupation & Income	Blood Group	Aadhaar

A) I hereby certify that:
   i) I am/am not engaged in any trade/business/profession. I am/am not also employed either under Government or private;
   ii) my family member(s) indicated above fulfill the conditions prescribed for registration under CHSS.
   iii) myself or my family member(s) is not getting any medical assistance/allowance from any source.
B) I hereby undertake to pay my contributions as per CHSS.
C) I understand that my family member(s) and myself can avail medical facilities only as admissible under CHSS.

Date: Signature

(Note: A stamp-size photo is to be produced with this form)

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(To be forwarded through respective Administration)

The information furnished at S.No.1 to 12 are verified and found to be correct.

Date: Signature
(seal)

To
CHSS OFFICE, DAE Hospital, Kalpakkam 603 102.

CONDITIONS FOR REGISTRATION OF RETIRED EMPLOYEES UNDER CHSS

The concessions under the Contributory Health Services Scheme shall be admissible to retired employees of DAE/NPCIL Units from the places where CHSS is already operation or persons who had already retired from DAE/NPC Units in Kalpakkam/Chennai subject to the following conditions:

1. The retired employee should have put in a minimum 5 years service in the Department before his/her retirement.

2. For persons who had retired before 1.8.1993 at Kalpakkam/Chennai, the contribution will be recovered w.e.f. 1.8.1993. In case of others, the contribution will be recovered from the following month of retirement.

3. For persons who had retired outside Kalpakkam/Chennai where CHSS is in operation, the contribution will be recovered from the following month of retirement.

4. The retired employee may settle down anywhere in India after retirement, but treatment can be availed as per CHSS.

5. Retired employees of the Department who opt for the benefits of the Scheme should pay the contribution in advance for a minimum period of one calendar year and the contribution shall be with reference to the pay drawn by him/her prior to retirement/ invalidation. Employees may also have an option to pay one time contribution for ten years to be eligible for life long registration.

6. Employees who are retiring voluntarily will be eligible for continuing registration under the Scheme provided they pay an enhanced contribution at the rate of three times of normal rate of contribution. However, the retired employees with 30 years of qualifying service need pay contribution at normal rate and those with less than this but with 25 years of such service at double the normal rate.(DAE OM No.1/7/99/IR&W/2000 dated 27.7.2000).

7. Those employees retired from places where CHSS is not available and settled down in a place where CHSS is available may also become members of the Scheme.

8. If life long registration is not done, it is obligatory on the part of the retired employees to revalidate the registration every year after filling in a declaration form to the effect that they do not avail of medical facilities from any other sources. [Note:If the Employee joins the Scheme after a gap on retirement, his/her last pay drawn attached to the post held by him, to be revised notionally from time to time and CHSS contribution to be calculated on the basis of pay, that would have been admissible on the date of application for life-time registration, had he/she continued in service (DAE OM No.7/8/2015/IR&W/11378 dated 29.08.2016)].

9. No person who is receiving or is eligible to receive medical aid/ facility/cash subsidy, cash allowance or reimbursement for medical care from any source other than this Scheme, shall be admitted to the Scheme without the explicit permission and subject to such restrictions as may be imposed by CHSS.

10. The basic pay last drawn by the retired employee will be basis for determining entitlement under CHSS wherever required.

11. The benefits of the Scheme will continue to be made available to the family member(s) of the retired employees who is/are covered by the definition of "family" in the Family Pension Rules even after their death subject to payment of appropriate contribution and fulfillment of other conditions.

(NOTE: CHSS contribution shall be paid by a demand draft/Banker's cheque drawn in favour of "Accounts Officer, GSO" payable at Kalpakkam SBI/Canara Bank.

APPLICATION FOR EXTENSION OF CHSS FACILITIES AT KALPAKKAM TO THE FAMILY OF DECEASED EMPLOYEE

1. Name of Applicant (CAPITAL LETTERS)			
2. Relationship to deceased employee			
3. Name of deceased employee/CHSS NO.			
4. Designation		5. ICNO.	
6. Section		7. Unit	
8. Basic pay last drawn	Pay:Rs. Grade Pay:Rs.	9. Date of joining in DAE	
10. Date of death of employee		11.Whether the family covered under CHSS?	
12.a) Present address Pincode: Phone No.		b) Address for correspondence: Pincode: Phone No.	
13. Period upto which medical facility is required to the family			
14. Reason for requesting extension of CHSS medical facilities			
15. Whether getting medical facilities from any other source or allowance if any?			

16. List of family members covered under CHSS and requiring medical facilities now:

S.No.	Name (CAPITAL LETTERS)	Relationship to deceased employee	Date of birth	Aadhaar	Blood group

I will abide to the terms and conditions of the CHSS at Kalpakkam and also agree to pay required contribution as per the CHSS.

Date: Signature:_____

(To be forwarded through respective Administrative Office)

It is certified that the details given above were verified and found correct. It is also certified that late _____ has completed one year service on the date of death and the last basic pay drawn was Rs._____.
Equivalent pay as per 7 CPC is _____

Date: Signature:
(seal)

APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES TOWARDS CONSULTATION WITH AUTHORISED MEDICAL ATTENDANT (AMA)

(Applicable for 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	Qty.	Amount Rs. P.
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
			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
CHSS Clinic, IMSc, C.I.T. Campus, Taramani, CHENNAI 600 113

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/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 are not stocked in the Clinic and do not include any proprietary preparations for which cheaper substitutes are available, 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 Authorised Medical Attendant

[Reg. No.] & Seal

Clinic address:

PRE – RECEIPT

Received an amount of **Rs.**_____**/-** (Rupees _____ _____ only) from Pay & Accounts Officer, MRAU, DPS, Chennai/_____ 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 : _____

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					
			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.)

Clinic address: [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 : _____

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.:_____
   (Please furnish a copy of card)

   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 @ Rs. _____ per day	: _____	From _____ to _____
b.Operation charges (if any)	: _____	
c.Consultation/Professional charges	: _____	No. of times: _____
d.Lab investigation charges	: _____	No. of tests: _____
e.X-ray charges	: _____	No. of X-rays: _____
g.Dressing/Suturing charges	: _____	No. of dressing: ____
i.Injection administering charges	: _____	No. of inj.: _____
j.Other charges (if any) with details	:	

Datewise consultation fees paid

Date	Fees

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

h.Details of medicines/injections given:

Bill No.	Date	Amount

Total Rs.

Date:

Signature of the Doctor
(Seal)

APPLICATION FORM FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES

1.a.Name of the Employee: _____
(CAPITAL LETTERS)
b.Designation: _____ c.ICNo.:_____ d.Section:_____
e.Unit: _____ f.Ph.No.:_____ g.Basic pay:Rs.___
h.Residential address:_____
i.Whether spouse is also working ? : Yes / No
If yes, Name: Designation:
Pay:Rs. ICNo.: Dept./Unit:

2.a.Name of the patient: _____
b.Age: _____ c.Medical card No.:_____ d.Relationship:____
to employee

3.a.Name of the Hospital/Centre/Lab/ : _____
Specialist and address to which
the patient referred for _____

* b.Referral letter dated : _____
c.Nature of treatment / period : _____

4.a.In case of Chennai beneficiary furnish
Authorised Medical Attendant consulted:_____
b.Registration No. :_____
c.Clinic address :_____
d.Date(s) of consultation :_____

5. If this claim is for reimbursement of expenses like spectacles/orthopaedic appliances etc., indicate whether any reimbursement obtained earlier ? : Yes / No
If yes, a.Name of the item purchased :
b.Date of purchase: c.Amount reimbursed:Rs.

6. Details of the bill(s) enclosed with the claim:

S.No.	Bill No.	Date	Amount	Particulars

7. Total amount : Rs.
8. Advance drawn, if any : Rs.
9. Advance amount refunded, if any : Rs.
10. Balance amount claimed : Rs.

Date: Signature

(*NOTE: A copy of referral letter is to be enclosed with this claim)

To
CHSS OFFICE, DAE Hospital, Kalpakkam 603 102.

ESSENTIALITY CERTIFICATE - `A'

Certificate granted to _____
wife/husband/son/daughter of _____ employed in the _____.

I, Dr._____ hereby certify:-

a) that I charged and received Rs._____ for ____ consultation(s) on _____ (date(s) to be given) at my consulting room/at the residence of the patient;

b) that I charged and received Rs._____ for administering ____ intra-veneous/intra-muscular/subcutaneous injections on _____ _____(date(s) to be given) at my consulting room/residence of the patient;

c) that the injections administered were not/were for immunising or prophylactic purposes;

d) that the patient has been under treatment at _____ hospital/my consulting room and that the undermentioned medicines prescribed by me in this connection were essential for the recovery/ prevention of serious deterioration in the condition of the patient. The medicines are not stocked in the _____ (name of hospital/dispensary/clinic) for supply to private patients and do not include any proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations, which are primarily foods, toilets or disinfectants;

	Name of medicines	Price	Bill No. & date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

e) that the patient is/was suffering from _____ and is/was under my treatment from _____ to _____;

f) that the patient is/was not given pre-natal or post-natal treatment;

g) that the X-ray, laboratory test etc., for which an expenditure of Rs._____ incurred was necessary and were undertaken on my advice at _____(name of the hospital or laboratory);

h) that I referred the patient to Dr._____ for specialist consultation and that the necessary approval of the _____ as required under the rules was obtained;

i) that the patient did not require/required hospitalisation.

Signature of AMA/Medical Officer
with Registration No. & seal

Date:_____

APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES

(Kalpakkam/Anupuram)

1. Name of employee: _____ 2.ICNo.:_____
   (Capital letters)
3. Designation: _____4.Section: _____5.Ph.No._____ 6.Unit:_____

7. Address: _____

8. Name of the patient: _____ 9.CHSS No.:_____
   (Capital letters)
10. Relationship to employee: _____ 11.Date of birth & age: _____ & ___

12. Validity date of medical card: _____
    (In case of retired/deceased employee family/parents/children above 18 years of age)

13. Name of the Doctor consulted: Dr._____

14. Treatment taken for: _____ 15.Date of prescription : _____

16. Details of bill(s) enclosed and medicine(s) purchased:

S. No.	Bill No.	Date	Name of medicine (in capital letters)	Qty.	Amount

17. Medicines purchased from (name of the Pharmacy):_____

Registration Number: _____ Place: _____

Date: Signature: _____

Encl.: Original prescription; Original bill(s) Name: ( )

S.No.:_____ (DAE HOSPITAL USE) Date: _____

I, Dr. _____ hereby certify that the above mentioned patient was under my treatment and the medicine(s) prescribed by me as indicated above was/were essential for recovery of the patient. The medicine(s) was/were not available in the DAE Hospital on the date of prescription issued and do not include proprietary preparations for which cheaper substitutes are available and which are not primarily food supplementary/toiletry/ cosmetic/disinfectant items.

The patient was suffering from _____.

Rs._____

Date: Signature of Medical Officer Medical Superintendent
(If amount exceeds Rs.1500/-)

To
Accounts Officer, _____

(For use in Accounts Section)

Passed for payment of Rs._____ through salary for the month of _____.

DA/AA AAO/AO

Contributory Health Service Scheme (CHSS), Department of Atomic Energy, Kalpakkam 603102

REFERENCE LETTER

(To be used for CHSS beneficiary by the Authorized Medical Attendant (AMA) nominated under CHSS)

(indicate name & address of center)

To Date: _____

_____

Sir,

I am herewith referring a case whose details are given below:

Name of patient : _____ Sex: M / F Age: ____ years;

CHSS card No._____ Validity of card: _____ Relationship to employee: _____

Address: _____

Name of employee: _____ Designation: _____

Pay:Rs. _____ ICNo._____ Unit: _____ Phone: _____

Brief case history / findings	Referred for

The bill for the treatment/tests along with details quoting the patient's name, CHSS card Number, employee's name and Unit may please be sent to the Medical Superintendent, Department of Atomic Energy Hospital, Kalpakkam 603102 for arranging payment.

Thanking you,

Yours faithfully,

AMA's name: Dr. _____
Registration No. _____

Clinic address: _____ Signature (with date)
AMA seal

_____

Phone number: _____

NOTE to centers: Letter without required details need not be accepted. Enclose a copy of this reference letter and a copy of CHSS card of the patient with the bill without fail.

Centers recognized for issuing of referral letter:

1	LISTER METROPOLIS HEALTHCARE LIMITED, 3, Jagannathan Road, Nungambakkam, CHENNAI 600 034 (Ph: 42055555)	**All investigations**
2	NEUBERG EHRLICH LABORATORY PRIVATE LIMITED, 19, Masilamani Road, Royapettah, CHENNAI 600 014 (Ph: 28130514/28130460)	**All investigations**
3	MEDISCAN SYSTEMS, 197, (Old No.92), Doctor Natesan Road, (Near Chennai City Centre), Mylapore, CHENNAI 600 004 (Ph. 24663232)	**Ultra sonogram tests**