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: _____**

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)