Checklist Form

(To be filled by the claimant)

1. Full name of the card holder : (Block Letters)
2. Health Card No. /Identity Card No : :
3. Pay in Pay Band/Grade Pay /Entitlement for Ward :
4. Full Address. :
5. Telephone No./ Mobile No. :
6. Email Address, if any :
7. Name of the bank.....Branch.....
   SB A/c Branch MICR code..... Tel No. of Bank branch.....
8. Name of the patient & relationship : With the card Holder
9. Whether Serving employee or Pensioner :
10. Basic pay/ Basic pension & Last Pay Drawn :
11. Name of the hospital with address:
    (A) OPD Treatment and Investigations :
    (B) Indoor Treatment :
12. Date of admission..... Date of Discharge.....(In case of indoor Treatment only)
13. Total amount claimed
    (A) OPD Treatment (Admissible, If any) :
    (B) Indoor Treatment :
14. Details of Permission (if any) :
15. Details of medical advance if any :

Declaration

I herby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I agree for the reimbursement as is admissible under the rules.

Dated: Signature of Applicant

Note: Misuse of Medical facilities is a criminal offence. Suitable action including cancellation of CBSE Health card shall be taken in case of wiliful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.

Information

(A) Kindly write correct postal address in block letters.

(B) Obtain break up of investigations from the hospital (details and rates of individual tests and the exact number of sugar test, X-ray films, etc.) for assessment of admissibility of claimed amount on various procedures.

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ESSENTIALITY CERTIFICATE

CERTIFICATE "B"

(To be completed in the case of patients WHO ARE ADMITTED to Hospital for treatment)

Certificate granted to Mrs./Mr./Miss. .....
father/mother/husband/wife/son/daughter of Mr./Mrs./Miss .....
.....
employed in .....

Photo to be attested by the Hospital Authority

PART "A"

I, Dr. ..... hereby certify :-

a) that the patient was admitted to hospital on the advice of ..... (name of the medical officer)/on my advice;

b) that the patient has been under treatment at ..... and that the under mentioned 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 the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets or disinfectants.

NAME OF MEDICINES	PRICE
1.	.....
2.	.....
3.	.....
4.	.....
5.	.....

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

d) that the patient is/was suffering from ..... and is/was under treatment from ..... to .....;

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

f) that I called on Dr. ..... for specialist consultation and that the necessary approval of the ..... (name of the Chief Administrative Medical Officer of the State) as required under the rules, was obtained.