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

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 : ____________________