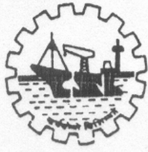

कोचीन शिपयार्ड लिमिटेड चिकित्सा सहाय योजना

COCHIN SHIPYARD LIMITED MEDICAL ASSISTANCE SCHEME

अंतरंग रोगी चिकित्सा की प्रतिपूर्ती के लिए प्रपत्र

FORM FOR MEDICAL REIMBURSEMENT FOR INPATIENT TREATMENT

Name of employee	Designation	Basic Pay	Department	Code No.

1. Name of Patient & Age :
2. Relationship to the Employee :
3. Residential Address :
4. Period of Treatment : From.. to..
5. Inpatient Number :
6. Name & Regn No. of AMA/ :
   Hospital / Nursing Home :
7. (a) Name of illness :
   (b) Name of Operation, if any :
   (to be filled in by the AMA) :
8. Amounts claimed (A) Consultation Fee

Sl. No.	Date of consultation	Bill No. & Date	Amount	(Rs.)
		TOTAL (A)		

(b) **Nursing Home/ Hospital Charges** (Please support by cash vouchers countersigned by AMA together with details of operation/professional services etc. Use annexures, if required)

Sl. No.	Particulars	No of days/ Times	Bill No. & Date	Amount (Rs)
1.	Room Rent (From to)	....	....	....
2.	ICU (From to)	....	....	....
3.	Nursing Care/Medical Supervision / Treatment..........	....	....	....
4.	Dressing	....	....	....
5.	Operation Charges	....	....	....
6.	Theatre Charges	....	....	....
7.	Anaestheia	....	....	....
8.	Anaesthetic Fee	....	....	....
9.	Assistance Fee	....	....	....
10.	Labour Room Charges	....	....	....
11.	Delivery Charge	....	....	....
12.	Cost of special drugs (Give details)	....	....	....
13.	Injection Charges	....	....	....
14.	Professional Charges (Give details)	....	....	....
15.	....	....	....	....
16.	....	....	....	....
17.	....	....	....	....
18.	....	....	....	....
19.	....	....	....	....
20.	....	....	....	....
21.	....	....	....	....
22.	....	....	....	....
	TOTAL (B)			

(C) **Medicines** (Please support claim by Doctor's prescription and cash vouchers of purchase countersigned by Authorised Medical Attendant. Use additional sheets if required)

Sl. No.	Name of Medicines (In block letters)	Bill No. & Date	Amount Rs.	Ps.
		TOTAL (C)		

(D) **Other Charges** (Please support by cash vouchers countersigned by AMA together with details of each test such as No. of tests size & No. of films used, rate per test etc. Use annexures if required)

Sl. No.	Particulars	Bill No. & Date	Amount (Rs)	
1.	X-ray (size & No. of films)............	....	....	....
2.	ECG	....	....	....
3.	Scan Charges	....	....	....
4.	Lab Tests (Specify name of test)	....	....	....
	(a)............	....	....	....
	(b)	....	....	....
	(c)............	....	....	....
	(d)............	....	....	....
5.	....	....	....	....
6.	....	....	....	....
7.	....	....	....	....
8.	....	....	....	....
9.	....	....	....	....
10.	....	....	....	....
11.	....	....	....	....
12.	....	....	....	....
		TOTAL (D)		
	Total (A+B+C+D) Rs			

MEDICAL ADVANCE DRAWN, IF ANY

Certified that the above claims are bonafide and in accordance with the CSL Medical Assistance Scheme.

Also certified that .... is solely dependent on me and is residing with me/my family at .... Monthly income of my father / mother is Rs.. only.

Date :-

Signature of employee

Name :

Phone Extn. No.

Medicines are as prescribed by me Rs...................................... has been paid to me as consultation fee Treatment above is as authorised by me.

(Hospital Seal)

Countersignature of the AMA
with Seal & Regn No.

Admitted for Rs.......................................

Accountant

Controlling Officer