MAR THOMA SYRIAN CHURCH OF MALABAR

Application Form for Reimbursement of Medical Aid Scheme for Clergy & their Families - (Amended) 2015 – *Revised form w.e.f. 01.10.2019*

(One form for each occasion of treatment for each patient)

1. Name of Applicant : P.F.No.:

2. Address of Applicant :

3. Name of Patient : Age :

4. If members of family
   a) Relationship with the applicant :
   b) Whether employed / drawing pension / other income :
   c) Whether sole dependent of the member / applicant :

5. Nature of illness :

6. Whether pre-existing illness or not :

7. Period of treatment (Specify with dates) :

8. Name of Doctor who treated :

9. Name of Hospital where treatment was taken :

10. Number of days for which room rent was paid in the Hospital :

11. Whether Clergy Medical Aid offertory is remitted from Parish / parishes under your care :

12. Details of expenditure
   a) Out Patient Bill Amount : 0.00
   b) Inpatient Bill Amount : 0.00

TOTAL ***Rs.*** 0.00

[Rupees. ..... only]

13. Have you received Medical Aid : from any other source?
If yes, furnish details

14. **Declaration**

The information given above is true to the best of my knowledge. I have read the rules of the Medical Aid Scheme and agree to abide by it.

Please send the Medical Reimbursement to the following Bank Account. I take responsibility about the correctness of the Bank Account details written below.

Name: ***Bank A/c No:***

Bank & Branch: ***IFSC:***

Place:
Date: Signature of the Applicant

Recommendation of the Diocesan Episcopa

Place:
Date: [Office Seal] Signature of the Diocesan Episcopa

PS: ***Incomplete application forms will not be accepted.***
Enclose a copy of the front page of Bank Pass Book for verification.

ABSTRACT OF MEDICAL BILLS – *Revised form w.e.f. 01.10.2019*

Sl. No.	Bill		Amount of Bills				Remarks
	No.	Date	OP Bills		IP Bills		
			Rs.	Ps.	Rs.	Ps.	
1.							
2.							
3.							
TOTAL			0.00		0.00		

Date: **Signature of the Applicant**

Note: ***Forward this application along with original bills and the following documents:***

1. Doctor's prescription with OP Bills.
2. Treatment Certificate in prescribed form or Discharge Summary from Hospital with IP Bills.

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Treatment Certificate – *Revised form w.e.f. 01.10.2019*

To be accompanied with Reimbursement claim **(if Discharge Summary is not attached)**

FOR HOSPITALIZATION/DOMICILIARY TREATMENT

To be completed by a Medical Practitioner only

1. Name and address of patient :

2. Age :

3. Date of Admission and IP No. :

4. Diagnosis :
(Cause and extent of injury
in case of accidents)

5. Date if first consultation with you :
(With O.P. No. & Date)

6. History of the Case

a) According to you, how long the person would have been suffering from this illness? :

b) Whether the disease is caused due to any congenital defects? :

c) Whether the disease / injury caused directly or indirectly due to the use of intoxicants or drugs? :

7. Details of diagnostic tests carried out prior to hospitalization :

8. Date and time of discharge :

9. Any post-hospitalization treatment advised, if so, give details :

10. If the patient was treated at home the reason for non-hospitalization :

11. Further remarks if any :

"Certified that the details furnished above are true to the best of my knowledge and as per his/her records available at this hospital"

Hospital:
Date:

Signature :
Name :
& Address

Seal:

Registration No. :