MAR THOMA SYRIAN CHURCH OF MALABAR

Application Form for reimbursement of Medical Aid Scheme

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

Kindly fill in all the Columns

1. Name of Applicant :
2. P.F. Account No. :
3. Address of Applicant :

4. Name of Patient : Age :
5. If members of family
   a) Relationship with the applicant :
   b) Whether employed / drawing pension / other income :
   c) Whether sole dependent of the member / applicant :
6. Nature of illness :
7. Whether pre-existing illness or not :
8. Period of treatment (Specify with dates) :
9. Name of Doctor who treated :
10. Name of Hospital where treatment was taken :
11. Number of days for which room rent was paid in the Hospital :
12. Whether Clergy Medical Aid offertory is remitted from parish/parishes under your care :
13. Details of expenditure
    a) Out Patient Bill Amount :
    b) Inpatient Bill Amount

TOTAL ***Rs.***

[Rupees. ..... only]

14. Have you received Medical Aid from any other source? If yes, furnish details :
15. 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.

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

ABSTRACT OF MEDICAL BILLS

Sl. No	Bill		Amount of Bills				Remarks
	No.	Date	OP Bills		IP Bills		
			Rs	Ps.	Rs.	Ps.	
TOTAL							

Date :

Signature of the Applicant

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

1. Doctor's prescription with OP Bills.
2. Treatment Certificate in prescribed form and discharge Card (original) from Hospital for IP Bills.

MEDICAL REPORT TO BE ACCOMPANIED FOR MEDICAL REIMBURSEMENT (UNDER HOSPITALIZATION/DOMICILIARY HOSPITALIZATION)

(To be completed by 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 in 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 whether hospitalization was necessary and reason for non-hospitalization (Applicable in case of domiciliary hospitalization case only.) :

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 :

Registration No. :