MALANKARA MAR THOMA SYRIAN CHURCH

Application Form for Reimbursement of Medical Aid Scheme for Clergy & their Families - (Amended) 2022

***Revised form w.e.f. 01.01.2023*- FOR OP BILLS ONLY**

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

1. Name of Applicant :

2. P. F. No. :

3. Address of Applicant :

4. Name of Patient :

5. DOB & Age of Patient :

6. Relationship with the applicant :

7. Nature of illness :

8. Whether pre-existing illness or not :

9. Period of treatment (Specify with dates) :

10. Name of Doctor who treated :

11. Name of Hospital where treatment was taken :

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

13. Details of expenditure – Total Outpatient Bill Amount: (As mentioned overleaf)

[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. 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 Account Number :

Bank & Branch :

IFSC :

Place:

Date: Signature of the Applicant

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

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

Date: **Signature of the Applicant**

Note: ***1. Forward this application along with original bills and Doctor's prescription.***
2. This form can be used for both OP and IP reimbursement for clergy 85 years and above

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. :