KERALA POLICE HOUSING CO- OPERATIVE SOCIETY LTD NO 4348

ELAMKULAM, KOCHI - 20

0484-2313981, 2321503, 9846101101, 9846101102
Email id: kphcsekm@yahoo.co.in

CRITICAL AILMENT RELIEF ENDOWMENT

CLAIM FORM

MEMBER NO :	CARE NO :	CPAS NO:

I	A	Name of Applicant	
	B	Rank & GL No	
	C	Unit	
	D	Address	
	E	Phone No.	

II DETAILS OF HOSPITALISATION

A	Name of patient	
B	Age	
C	Relationship	
D	Address	
E	Name and Address of the Hospital	
F	Hospital Inpatient No.	
G	Hospital OP No.	
H	Nature of Disease/ illness	
I	Date of Admission	
J	Date of Discharge	

III **DETAILS OF AMOUNT CLAIMED**

SINO	ITEMS	AMOUNT CLAIMED	FOR OFFICE USE ONLY	
			AMOUNT PAYABLE	AMOUNT PAYABLE
1	Doctors Consulting Fee			
2	Nursing Charges			
3	Room Rent			
4	ICU Charges			
5	Diagnostic materials and X -ray etc			
6	Operation Charges			
7	Cost of Medicines and Drugs			
8	Other Hospital Expenses - details			
	TOTAL			

IV a. Amount Previously claimed :
b. Amount applied
c. Total Amount Claimed (a + b)

I here by declare that the above Statements are true to the best of my knowledge.

Place :
Date :

Signature :
Name of Applicant :

Recommendation by Board Member

FOR OFFICE USE ONLY

Prepared by :	Total Amount claimed Rs.
Checked by :	Amount not payable Rs.
Approved by Board Resolution No and date :	Net Amount payable Rs.

Passed for payment of Rs.....

Place
Date

SECRETARY
KPHCS, LTD NO 4348
ERNAKULAM

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MEDICAL CERTIFICATE (Alopathy / Ayurvedic / Homeopathy)

To be filled by the consulting Physician/ Surgeon

1	Name and address of the Patient	:	
2	Age of the Patient	:	
3	Name of the Hospital treatment was taken	:	
4	1) Date of Admission	:	
	2) Date of Discharge	:	
5	Hospital Inpatient No	:	
6	Hospital OP No	:	
7	Are you the regular medical practitioner of the patient ?	:	Yes/ No
8	Describe fully the nature of illness	:	
9	Describe fully the nature of treatment	:	
10	Was the patient referred to you by some other Doctor/ Hospital ?	:	Yes/ No
	If yes		
	a) Name and address of the Doctor/ Hospital	:	
	b) Diagnosis of the previous Doctor/ Hospital	:	
11	Probable duration of the illness when the patient was first attended by you		
12	Other Remarks	:	

I certify that the above named patient was treated in the Hospital and the details given above are true to the best of my knowledge.

Place :
Date :

(Office Seal)

Signature :
Name of the Docto :
Registration No :
Address :