

**KERALA POLICE HOUSING
CO-OPERATIVE SOCIETY LTD No.4348**

H.O: ERNAKULAM -20

Branches : Thiruvananthapuram, Kozhikode

Head Office Ph: 0484 -2313981, 9846101101, 9846101102 e-mail: kphcsekm@gmail.com

Thiruvananthapuram Branch Ph: 9495469101, e-mail: kphcstvm@gmail.com

Kozhikode Branch Ph: 8281551101 e-mail: kphcskkd@gmail.com

website: www.kphcs.com

CARE PLUS FORM

MEMBER No.	SCHEME No
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I

A	Name of Applicant	
B	Rank & GL.No	
C	Unit	
D	Office Address	Residential 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/Injury/Illness	
I	Date of Admission	
J	Date of Discharge	
K	Present stage of Patient	

III. DETAILS OF AMOUNT CLAIMED

SL No	Items	Amount claimed	FOR OFFICE USE ONLY	
			Amount Payable	Amount Paid
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 Now :

c. Total Claimed (a+b) :

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

Signature :

Name of Applicant :

Place : Member No :

Date : Scheme No :

FOR OFFICE USE ONLY

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

Passed for payment of Rs

Place :

SECRETARY

Date :

Kerala Police Housing Co
Operative Society Ltd No 4348
Ernakulam

DETAILS OF OTHER DOCUMENTS TO BE ATTACHED

- **DISCHARGE SUMMARY**
- **DISCHARGE BILL**
- **DETAILED BILL OF DISCHARGE BILL**
- **ADMISSION PERIOD OTHER CASH BILL**
- **ORIGINAL AND COPY TO BE SEPARATELY ATTESTED BY CONCERNED DOCTOR ITSELF**
- **HOSPITAL SEAL, DOCTOR SEAL AND DOCTOR SIGN AS ATTESTATION**
- **ONLY ADMISSION PERIOD BILLS TO BE SUBMITTED**

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MEDICAL CERTIFICATE

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 O P no :
7. Are you the regular medical
Practitioner of the patient? : Yes/No
8. Describe fully the nature of illness /Injury :
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 : Signature :

Date (Office Seal) Name of the Doctor :
Registration No :
Address :



VOUCHER

Date :

KERALA POLICE HOUSING CO-OPERATIVE SOCIETY LTD., NO. 4348

H.O Elamkulam, Kochi -20, Br. Thiruvananthapuram, Kozhikode

Particulars	Amount	
	Rs.	Ps.

Checked, Recommended for Payment of
Rs.....

Accountant

Passed of Payment of Rs.....

Secretary

Received a sum of Rs.....

.....only) by cash/

Cheque No.....dt.....of.....

.....Bank.....

Name & Signature of Payee

BANK ACCOUNT DETAILS

MEMBER NO :

NAME :

RANK & GLNo :

PEN :

NAME OF BANK :

BRANCH :

ACCOUNT NO :

IFSC CODE :