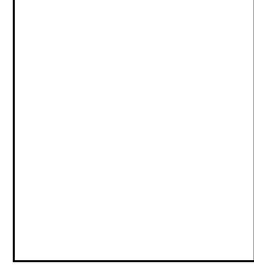
AP CHIEF MINISTER's RELIEF FUND

Application form for Letter of Credit (LOC)



Latest Photo of the Patient

To
The Hon'ble Chief Minister,
Govt. of Andhra Pradesh,
A. P. Secretariat,
Velagapudi,
Amaravathi.

PART-A TO BE FILLED IN BY THE PATIENT/APPLICANT

(TO BE FILLED IN BLOCK LETTERS ONLY)

(A) Name of the Patient :

(B) Aadhaar Card No: of the Patient :

(C) Mobile Number :

(D) Alternate Mobile Number :

(E) White Ration / Income Certificate No:

(F) Voter Id No :

(G) Son/Daughter/Wife of :

(H) Date of Birth and Age of the Patient:

(I)Address for Correspondence :

Door Number: Street:

Village: Mandal:

District: PIN:

Name of the Assembly Constituency:

If the Application is for a Child or an Admitted Patient (Please fill the below details)

a) Name of the Applicant :

b) Relationship to the patient :

c) Applicant Aadhaar Card no :

Name and Address of the Hospital at which Treatment is to be carried out:

Date:

Place: Signature of Applicant

For any Suggestions/Complaints : e-mail: mailcmrf@gmail.com Toll Free no: 1902

PART B: TO BE FILLED IN BY THE TREATING HOSPITAL:

(Fields must be filled in Block Letters) All the clinical details provided below need to be supported by evidence for Diagnosis and Cost in detail, in the enclosures (Ref to Part D for Mandatory Documents and Part E for format of Treatment cost estimation)

(A) Name of the Patient :

(B) Son/Daughter/Wife of :

(C) Age and Sex of the Patient :

(D) OP / IP Number :

(E) Diagnosis :

(F) Treatment planned :

(G) Probable total duration of treatment:

(H) Estimated cost of treatment : Rs

(I) Name of the Hospital at which treatment is to be carried out :

(J) Address of the Hospital :

(K) Registration Number of the Hospital with DM& HO concerned:

(L) Name of the Treating Doctor:
Specialty:
Phone: Email id:

(M) Name of the Signing Authority for the Hospital:
Phone: Email id:

(N) Single Point of Contact with the Hospital:
Name of the Person:
Phone: Email id:

NB: The applications for Letter of Credit for Diseases already covered under various **Govt. schemes**, Normal Deliveries, Caesarean Sections, Hysterectomies, Cataracts, Elective treatments / Procedures covered under "**DR.YSR Aarogyasri**" in Network Hospitals will not be processed The Hospital should not collect money from the applicants for any purpose for the amounts already mentioned in the estimation.

*****Name &Signature of the Aarogyamitra
With Date

* Name &Signature of Treating Doctor
With Stamp

For any Suggestions/Complaints : e-mail: mailcmrf@gmail.com Toll Free no: 1902

PART C: FORMAT OF TREATMENT COST ESTIMATION, FROM THE TREATING HOSPITAL

PATIENT DETAILS:

Name & Address of the Hospital :

Name of the Patient :

Gender: Male/Female/Others : Age :

OP /IP No :

Diagnosis :

Treatment Planned :

Treatment cost estimation

S.No	Patient Service	Estimated Cost Rs.
1	Lab Investigations Pre Op / Pre Treatment Post Op / Post Treatment	
2	Imaging Pre Op / Pre Treatment Post Op / Post Treatment	
3	Medical Management/ Surgery/ Implants/ Consumables	
4	Type of Stay x No. of Days Pre Op / Pre Treatment Post Op / Post Treatment	
5	Miscellaneous if any	
	Total	

Date:

Place:

Signature of Treating Doctor
with Stamp

Note: Same format can be used for providing more details

For any Suggestions/Complaints : e-mail: mailcmrf@gmail.com Toll Free no: 1902

PART D: LIST OF MANDATORY ENCLOSURES FOR APPLICATION:

- Copy of White Ration / Rice Card / Income Certificate, Aadhaar Card
- 2 working mobile phone numbers
- Photo of the patient (Emergency: On bed / Elective: Passport size)
- Evidence for Diagnosis: Lab Reports / Radiographs / Reports of Scans / Biopsy
- For Medical Management / Chemotherapy / Radiation: Detailed estimated cost of treatment including Details of Drugs to be used for on Hospital Letter head
- For Surgical / Invasive Procedures: Detailed estimated cost of treatment along with cost of Implants / Prosthesis on Hospital Letter head
- Hospital Phone number for Single point of contact
- Treating Doctor Contact Details
- Copy of Hospital Registration Certificate with DM&HO concerned

With Hospital Bills after treatment, to be furnished by treating Hospital within 15 days from the date of Discharge of the Patient

- Cover letter for Hospital Bills with Bank Account details of the Hospital viz, Name of Account Holder, A/c no:, Name of the Bank, Branch, IFSC, TIN, PAN
- Original Letter of Credit
- Photo of the Patient: On bed photo during treatment
- Evidence for Treatment: Intra Operative photo / On bed photo with Medication, Face and Case Sheet of the patient
- Copy of relevant Post therapy / Surgery documents like Lab / HPE / X Ray / CT / MRI Reports
- Copy of the case sheet
- Copy of Pre treatment Detailed Cost estimation
- Cost of treatment: Consolidated Bill and all invoices generated for the treatment along Implants with Signature and Stamp of the signing authority
- Copy of the Discharge summary with Signature and Stamp of the treating Doctor

Note: The applications for Letter of Credit for Diseases already covered under various **Govt.Schemes**, Normal Deliveries, Caesarean Sections, Hysterectomies, Cataracts, Elective treatments / Procedures covered under **DR.YSR Aarogyasri** in Network Hospitals will not be processed. Entire claim processing depends on documents produced after the treatment The document submission should be strictly similar to the claim submission guidelines of **DR.YSR Aarogyasri** Trust available on the trust web site for any given treatment / procedure **The Hospital should not collect money from the applicants more than estimation.**

PART E: FOR OFFICE USE ONLY

Checklist for DEO to be marked √ after verification

- CMRF Filled Application Form
- Copy of Aadhaar Card of the Patient
- Mobile Number 1 of the Patient/ Attendant
- Mobile Number 2 of the Patient/ Attendant
- Copy of White Ration / Rice Card or Income Certificate
- Copy of X ray, Scan, Biopsy Reports
- Detailed cost estimation
- Copy of Hospital Registration Certificate

Enclosures Verification Remarks of Data Entry Operator:

CMRF Ref No assigned to the File:

Name of the DEO: Signature of the DEO:

Verification Remarks of CMRF Doctor about Diagnosis and Treatment:

Name of the CMRF Doctor: Signature of the CMRF Doctor:

Approval / Rejection Remarks:

Signature: