AP CHIEF MINISTER's RELIEF FUND

Application form for Letter of Credit (LOC)

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

Latest Photo of the Patient

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

(TO BE FILLED IN BLOCK LETTERS ONLY)

(A) Aadhaar Card No: | | | | | | | | | | | | |

(B) Name of the Patient :

(C) Son/Daughter/Wife of :

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

(E) Mobile Number :

(F) Alternate Mobile Number :

(G) White Ration /Rice Card/ Income Certificate No :

(H) Address for Correspondence :

(I) 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:

DECLARATION: I Mr. /Mrs._____Son/daughter/wife of Mr. /Mrs. _____declare that the information given above is correct and complete in all aspects. I also declare that neither the patient nor the family dependents are employees of the Central / State Government and further no other assistance from neither State nor Central Government Schemes and Insurance Claims is received. In case if any such financial assistance is identified subsequently that, any fraudulent or misleading information has been furnished by me, I shall be liable for legal action as deemed.

Date:

Place: Signature of Applicant

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:

I, Mr./Mrs._____signing authority of (Hospital)_____ declare that information given above is correct and complete in all aspects, any fraudulent or misleading information has been furnished by me, I shall be liable for legal action as deemed.

*Name & Signature of Treating Doctor
With Stamp

PART C: 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

LOC Number:

Checklist for LOC

- ☐ CMRF Filled Application Form [Yes/No]
- ☐ Copy of Aadhaar Card of the Patient [Yes/No]
- ☐ Mobile Number 1 of the Patient/ Attendant [Yes/No]
- ☐ Mobile Number 2 of the Patient/ Attendant [Yes/No]
- ☐ Copy of White Ration / Rice Card or Income Certificate [Yes/No]
- ☐ Copy of X ray, Scan, Biopsy Reports [Yes/No]
- ☐ Detailed cost estimation [Yes/No]
- ☐ Copy of Hospital Registration Certificate [Yes/No]

Enclosures Verification Remarks of Data Entry Operator:

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: