AP CHIEF MINISTER's RELIEF FUND

Application form for REIMBURSEMENT

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

Latest Photo of the Patient

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 Card / Income Certificate No:

(F) Voter Id No :

(G) Son/Daughter/Wife of :

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

(I) Total Cost of medical expenses to be reimbursed Rs:

(J)Address for Correspondence :

Door Number: Street:

Village: Mandal:

District: PIN:

(K) Bank A/c Details of Applicant/ Family member:

Name of the Bank A/c Holder :

Name of the Bank & Branch :

A/c Number :

Name of the Assembly Constituency :

Recommended by :

(L) If the Application is for a child or a deceased person (Please fill the below details also)

a) Name of the Applicant :

b) Relationship to the Patient :

c) Birth / Death Certificate No of Patient:

d) Family member certificate No :

e) Applicant Aadhar Card Number :

(M) Name and Address of the Hospital at which Treatment is 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 the 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 Treatment in the enclosures. (Ref to Part D)

(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 done :

(G) Total Duration of the treatment :

(H) Cost of the treatment :

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

Registration Number of the Hospital with DM& HO concerned:

Door Number : Street :

Village, Mandal :

District : PIN :

Phone : Email id :

(J) Name of the Treating Doctor: Reg No & Medical Council:

Specialty :

Phone : Email id :

(K) Name of the Signing Authority for the Hospital:

Phone : Email id :

(L) Single Point of Contact with the Hospital :

Name : Contact No :

NB: The applications for reimbursement of medical expenses 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 application processing depends on all documents produced related to 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.

Name & Signature of Aarogyamitra

DECLARATION

I, Mr./Mrs._____signing authority of (Hospital)_____declare that information given above is correct and complete in all aspects. I also declare that the expenditure bills of this patient are not issued for claiming Central / State Government / Insurance benefits. In case if any such claims are 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 Treating Doctor

With Stamp

PART C: Verification Remarks for Office Use at CMRF

Checklist for DEO to be marked √ after verification

(A)Name of the Patient :

(B) Aadhar Card No. of the Patient :

(C) White Ration Card No. :

- ☐ Name of the Patient and Applicant :
- ☐ Copy of Aadhar Card of the Patient and Applicant :
- ☐ Patient / Applicant Mobile Number 1 :
- ☐ Patient / Applicant alternate Mobile Number 2 :
- ☐ Copy of White Ration/ Income Certificate :
- ☐ Copy of X ray, Scan, Biopsy Reports :
- ☐ Copy of Hospital Registration Certificate :
- ☐ Cost of treatment: Consolidated and all detailed bills generated for the treatment including medicines, implants with signature and stamp of the signing authority
- ☐ Copy of the case sheet
- ☐ Copy of the Discharge summary with Signature and Stamp of the treating Doctor
- ☐ Copy of First Page of Bank Pass Book
- ☐ Copy of Family Member Certificate in the case of deceased patient
- ☐ Copy of Birth / Death Certificate in the case of a child or a deceased person

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

PART D : List of Mandatory Enclosures to be Submitted

- 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 Aadhar Card of the Patient and Applicant:
- Mobile Number 1:
- Mobile Number 2:
- Copy of White Ration / Rice or Income Certificate
- Copy of Lab / HPE / X Ray / CT / MRI Reports: Pre treatment
- Copy of the case sheet
- Cost of treatment: Consolidated and all detailed bills generated for the treatment including medicines, implants with Signature and Stamp of the signing authority
- Copy of the Discharge summary with Signature and Stamp of the treating Doctor
- Copy of X ray, Scan, Biopsy Reports: Post Treatment
- Copy of Hospital Registration Certificate:
- Copy of First Page of Bank Pass Book of the Applicant
- Copy of Family Member Certificate in the case of deceased patient
- Copy of Birth / Death Certificate in the case of a child or a deceased person

NB: The applications for reimbursement of medical expenses 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 application should be submitted within 90 days after discharge from the Hospital. Entire application processing depends on documents produced. 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.