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 :

PIN CODE:

(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:

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:

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 NTR Vaidyaseva Trust**" 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 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:

AP CHIEF MINISTER'S RELIEF FUND

Application form for Reimbursement

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 :

PIN CODE:

(I) Name of the Assembly Constituency:

(J) Total Cost of Medical Expenses to be reimbursed Rs:

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

Name of the Bank A/C Holder:			
Bank A/C Number:			
Name of the Bank :		Branch:	
Bank IFSC code:			

(B) 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 Aadhaar Card Number :

(C) 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

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 Aadhaar Card of the Patient or Applicant (incase deceased):
- ☐ 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
- ☐ Cost of treatment: Final Consolidated bill and all original detailed bills for the treatment including medicines, implants, etc., with Signature and Stamp of the signing authority
- ☐ Original 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

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

(Fields must be filled in capital 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) Patient Aadhaar No :

(E) OP / IP Number :

(F) Cost of the treatment :

(G) Name of the Hospital and address :

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

(I) Name of the Treating Doctor :

Reg. No & Medical Council:

Specialty :

Phone : Email id :

(J) Single Point of Contact with the Hospital:

Name : Contact No

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: Signature of Signing Authority

Place: Stamp

CMRF Number:

Checklist for Reimbursement

- ☐ Copy of Aadhaar Card of the Patient and Applicant : [Yes/No]
- ☐ Patient / Applicant Mobile Number 1 : [Yes/No]
- ☐ Patient / Applicant alternate Mobile Number 2 : [Yes/No]
- ☐ Copy of White Ration /Rice Card or Income Certificate: [Yes/No]
- ☐ Copy of X ray, Scan, Biopsy Reports : [Yes/No]
- ☐ Copy of Hospital Registration Certificate : [Yes/No]
- ☐ Final Bill (Consolidated and all detailed bills generated for the treatment including medicines, implants with signature and stamp of the signing authority): [Yes/No]
- ☐ Original Discharge summary with Signature and Stamp of the treating Doctor: [Yes/No]
- ☐ Copy of First Page of Bank Pass Book : [Yes/No]
- ☐ Copy of Family Member Certificate in the case of deceased patient: [Yes/No]
- ☐ Copy of Birth / Death Certificate in the case of a child or a deceased person: [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