CHSS FORM No.7(A)

GOVERNMENT OF INDIA
DEPARTMENT OF SPACE

(Contributory Health Service Scheme)
(For Hospitalisation or Specialist Cases only)

Form of application for claiming reimbursement of the cost of medicines under the Contributory Health Service Scheme of the Department of Space.

(N.B.Separate form should be used for each patient)

1. Name and designation of Government Servant (In Block Letters) :
2. Office in which employed :
3. Actual residential address :
4. Name of the patient and his/her relationship to the Government Servant (N.B. in case of children state age also) :
5. Contributory Health Service Scheme Registration Card No. :
6. **Specialist Consultation**
   1. Name of the Specialist
   2. The number and date of consultation :
7. **Hospitalisation** :
   1. Name of Nursing Home/ Hospital/Polyclinic
   2. Period of stay :
8. Cost of medicines purchased from the market (Cash Memos attached) :
9. Amount claimed :

Declaration to be signed by the Government Servant

I hereby declare that the statement in this application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent upon me.

Signature of the Govt.Servant

P.T.O

I, Dr. _____ hereby certify

(a) * that the patient has been under my treatment and that the undermentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient.

OR

* that patient has been referred by me to the specialist and the undermentioned medicines have been prescribed by the Specialist.

Sl.No.	Name of the Medicine	Quantity	Price

b) that the patient is/was suffering from _____ and is / was under my treatment from _____ to _____

Station :
Date :

Signature of the Authorised
Medical Officer/Dept's Doctor

The Claim is passed for Rs._____ (Rupees _____ only)

Admn. Officer

Accountant

Received Rs._____(Rupees _____ only)

Signature of the Govt. Servant