RETIRED EMPLOYEES

MEDICAL FORM FOR REIMBURSEMENT OF MEDICAL CLAIMS OF RETIREES AS PER CENTRAL GOVERNMENT HEALTH SCHEME AND NEW MEDICAL SCHEME FOR RETIREES / SPOUSE IN V.O.CHIDAMBARANAR PORT TRUST

(To be filled by the Retired Employee / Spouse)

1. Retired Employee Card No. :
2. Validity of Card :
3. Full Name of Retired Employee/Spouse :
   (Block letters)
4. Full Residential Address :

5. Telephone / Mobile No. :
6. E.mail address if any :
7. Name of the Bank …….. Branch ……. SB A/c No. ……
   (In which Pension / Family Pension is credited)
   Branch MICR Code …… Telephone No. of Bank Branch …….
8. Name of Patient & Relationship with :
   Retired Employee / Spouse
9. Status tick (/) (Pensioner / Spouse / Family Pensioner)
10. Basic Pension / Family Pension :
11. Name of the Hospital with full address :
    (a) Outdoor treatment and investigations :
    (b) Indoor treatment :
12. Date of admission ……. Date of Discharge …….
    (In case of indoor treatment only)
13. Total amount claimed
    (a) Outdoor treatment and investigations :
    (b) Indoor treatment :
14. Details of Reference letter issued by CMO :
15. List of Enclosures like Cash Receipt, Investigation :
    Reports, discharge summary, etc.

DECLARATION

_____I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependant on me. I am a Pensioner / Family Pensioner and joined in the Medical Scheme covered under V. O.Chidambaranar Port Trust Employees' (Contributory Outdoor and Indoor Medical Benefit After Retirtement) Regulations, 1996. I agree for the reimbursement as per CGHS rate and the New Medical Scheme for Retirees / Spouse in V.O.Chidambaranar Port Trust.

Signature of Retired Employee / Spouse

Place :
Date :