THE MARITIME FLOATING STAFF WELFARE TRUST

Abhishek Premises, Gr. Floor, unit No. 1 & 2, Dalia Industrial Estate,
Kuber Complex Lane, Opp. SAB TV, New Link Road, Andheri (West), Mumbai - 400 053.
Tel.: 2673 0306 / 07 / 09 Email: mail@mfswt.com

DAY CARE TREATMENT FORM

MFSWT No.: _____

Particulars of the Officer

Name _____
Surname First Name Father's Name

Rank_____ Last Sign on _____ Last Sign off _____

Name of the last Vessel & Company Address _____

Residence Address _____

_____ Pin Code _____ Resi. Tel. No. _____

Mobile _____ Email : _____

Bank Details **(Only Savings Accounts. Kindly attach cancelled Cheque)**

Name of A/c Holder _____

Bank Name _____ IFSC _____

Account No._____Branch_____

Bank Address _____

_____Pin:_____

Particulars of the Patient

Name _____
Surname First Name Father's / Husband's Name

Date of Birth _____ Age: _____Relationship _____

Nature of Illness _____

Is the dependent patient employed YES / NO

If Yes Name of the Employer _____

I hereby declare that all the details of treatment and expenses incurred by me as given in section A,B,C & D overleaf are true to the best of my knowledge. I agree that if it is found that the above given statements are in any respect incorrect or untrue. The Medical Floating Staff Welfare Trust shall reject my appeal for reimbursement made by me or my wife.

Date _____ Signature _____
Employee (in his absence his wife)

(P.T.O.)

IMPORTANT: Please do not leave any items blank and attach all Bills, Receipts, Cash Memos, for Medicines

A. Surgeon's Charges (To be completed by Physician / Consultant)

Diagnosis _____

Procedure performed at _____

Admitted on _____at _____am / pm

Discharged on _____ at _____am / pm

No. of Consultation _____ at Rs. _____

Theatre Charges Rs. _____

Surgeon's Fees Rs. _____

Lens Charges Rs. _____

Medicines given by Doctor Rs. _____

Medicines purchased from Pharmacy Rs. _____

Investigation Rs. _____

Total Medical Expenses incurred Rs. _____

_____

Doctor's Stamp and Signature

Total amount of this appeal **Rs. _____**

In Words_____

Important:

1) Applicable entries must be supported by all original Bills and Receipts from respective parties i.e. Physician, Dentist, Consultants, Pharmacy, Laboratory etc.
2) It is mandatory for the Physician / Dentist / Surgeon / Consultant to fill up the required Items respectively.
3) Attach Photocopies of Prescription and Reports
4) Separate appeal should be submitted for each person and for each illness
5) Attach relevant copies of CDC and last Contract letter
6) Incase of examination leave kindly attach necessary proof for the same
7) Unsigned forms will be returned
8) Appeal for reimbursement should be submitted immediately after completion of the treatment but not later than three months.