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

HOSPITALISATION 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 _____

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 Medicities*

A. Hospital Room Charge

Admission / Registration Chages Rs. _____

Admitted on _____ at _____ am/ pm

Discharged on _____ at _____ am / pm

Charges for _____ days at Rs. _____ per day Rs._____

Total of Hospital Room Charges Rs._____

B. Details of Hospital Charges

1. Operation Theatre Charges Rs. _____
2. Oxygen, Blood Transfusion Rs. _____
3. MRI, C.T.Scan Rs. _____
4. Laboratory Charges Rs. _____
5. Investigation (Pre / Post) Rs. _____
6. Medicines from Hospital Rs. _____
7. Medicines from Market Rs. _____
8. Others Rs. _____

Total of Hospital Charges Rs._____

C. Surgeon's Fees (To be completed by the Surgeon / Gynaecologist)

Nature of Procedure _____

Fees for the above procedures Rs. _____

Assistant Charges (if any) Rs. _____

Total Surgeon's Fees Rs. _____

_____

Doctor's Stamp and Signature

D. Consultant's Fees (To be completed by Physician / Consultant)

Diagnosis _____

No. of Consultation _____ at Rs. _____

Total of Consultation Fees Rs. _____

E. Total amount of this appeal (A + B + C + D) Rs. _____

In Words _____

Important: **1)** Entries in Section A,B,C & D must be supported by all original Bills and receipts from respective parties i.e. Hospital, Surgeon, Consultants, Pharmacy, Laboratory etc. **2) It** is mandatory for the Surgeon / Consultant to fill up the respective Item C & D respectively. **3)** Photocopies of Prescription, Reports and Discharge Card and incase of Maternity photocopy of Child's Birth Certificate / Hospital certificate **4)** Attach relevant copies of CDC and last Contract letter **5)** Incase of examination leave kindly attach necessary proof for the same **6)** Unsigned forms will be returned. **7)** Appeal for reimbursement should be submitted immediately after completion of the treatment but not later than three months.