



The Maritime Floating Staff Welfare Trust

Regd. No. E-14328 (Bombay) 1993 - Regd. Under Maharashtra Public Trust Act, 1950

Unit No. 1 & 2 AB, Abhishek Premises, Gr. Floor, Kuber Complex Lane,
Veera Desai Industrial Estate, Off New Link Road, Andheri - (W), Mumbai - 400 053
Tel: 48015707 / 08 /09 Email: mail@mfswt.com Website: www.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 (Normal Savings Account of the Officer / Spouse)

Name of A/c Holder _____

Bank Name _____ IFSC Code _____

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 _____

Documents to be submitted:

- Original Bills and receipts.
- Photocopies of prescription, discharge card / discharge summary and reports.
- Photocopy of the last voyage contract letter and relevant copies of CDC (Photo page & last two voyage stamping page) must be submitted. Photocopy of current voyage stamping and contract in case the officer is on board.
- Photocopy of exam proof (Passing certificate / completion certificate, admission certificate, etc. Applicable in case the officer has been on leave for exams).

Important Notes:

- 1) Entries in Section A 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 to fill Section A.
- 3) Appeal for reimbursement should be submitted immediately after completion of treatment but not later than two months. Refer the medical brochure for further information.
- 4) Officer and family covered under personal TPA may refer to the medical brochure for further guidelines.
- 5) Ensure bills and receipts have Invoice numbers and invoice date.

(P.T.O.)

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.** _____

Declaration:

I, hereby declare that all the details of treatment and expenses incurred by me as given in section A is true and 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, then The Maritime Floating Staff Welfare Trust shall reject my appeal for reimbursement made by me or my spouse.

Date _____

Signature of Officer / Spouse