Khoja Shia Isnaashari Jamaat Mumbai

66/70 Hazrat Abbas (A. S.) Street, Dongri, Mumbai 400 009.
Tel: 23433473 / 23438317 / 65843775 Fax. 23433046
Email: info@ksijamat.org

General Medical Aid Form

Name of Pateint: _____ Age: _____
Son / Daughter / Wife of: _____
Family Members: _____ Family Income: _____ Occupation: _____
Address Complete: _____
_____ Telephone No.: _____
Nature of Disease: _____ Period of Sickness: _____
Name of Treating Doctor / Hospital: _____
Type of treatment (Medication / Investigation): _____
Total Expenses of treatment (with breakup) Rs: _____
Can arrange from other sources Rs: _____
Medical Aid required from Jamat Rs: _____
Membership No.: _____
Are you covered from Mediclaim Insurance: _____

Note:

1. Please attach copy of all related medical documents.
2. For Medication and Investigations please submit copy of Doctors prescription
3. For Surgery please submit Certificate from operating Surgeon stating nature of disease, Type of Treatment and Approx expense with detailed break-up
4. Enclose copy of Ration card / Proof of Residence / Adhar Card
5. Incomplete form will not be accepted / replied or returned.

Applicant Sign: _____

(For office use only)

Date of Receiving form: _____

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