DELHI DEVELOPMENT AUTHORITY
Application form for submitting claim for Indoor Claims.
(In general cases other than Death or loss of documents)

Part-A (informative):

1. Medical Card No. ----------
2. Designation ----------
3. Name of Employees/Pensioner/Section. ----------
4. Name of Hospital ----------
   a) Empanelled Yes/No
      OR Registered Yes/No
   b) Claimed amount. ----------
5. Basic Pay at the time of Admission Basic Pay: Grade Pay:
5 (a) Dependency certificate if required. _____
6 Name and IFSC of Bank _____
7. Savings Account No. ----------
8. Page No. of Claim papers From 1 to
9 Whether Medical Advance paid Yes/No.
10 Period of treatment From _____ to_____

Part-B (Mandatory documents to be attached Serial No. wise)

B-1 (In case of Empaneled Hospital)

1. Copy of Discharge Summary
2. All Original Cash Receipts
3. Original Bill
4. Detailed Bill (Break up of Bill)
5. Copy of Medical Card
6. Copy of Pay Slip for regular staff.
7. Copy of Medical contribution paid(for pensioners who have not paid 10 yrs. Contribution)
8. Hospital bank details (in case of medical advance)

B-2 (Additional in case of Registered Hospital)

1. Prescription Slips
2. Original Bills of Medicines/Tests etc.
   (Prescribed by hospital during Indoor Treatment Only)
3 Copy of Registration Certificate of Hospital
4. Emergency Certificate (if required)

Note:

- In cases of Cardiac Artery/Vascular Stenting and Cataract Surgery the Pouch of Stents and Sticker of lens respectively to be attached.
- Certificate issued by hospital may be produced in case of replacement of knee.
- In case of empaneled hospitals whether his/her identity was disclosed by the employee/pensioner of DDA at the time of hospitalization. (Yes/No)

Undertaking

I undertake to refund the amount, if any, found in excess/inadmissible amount from my pension/other dues/future payments.

(Signature of Claimant)

Name, Address and Contact No.:_____ _____

CONSENT LETTER

1.	Name of Employees/Pensioner/Section.	----------
2.	Designation	----------
3.	Medical Card No.	----------
4.	Name of Hospital	----------
	a) Empanelled	Yes/No
	OR Registered	Yes/No
	b) Claimed amount.	----------
5.	Period of Treatment	From……to……

I hereby give consent in favour of DDA/authority TPA/any other representative by DDA to have access to all medical treatment record including prescriptions/Lab record/medicine purchased/other requisite details.

_____
(Signature of Claimant)

Name _____

Address _____

Contact No._____