

**KARUNYA BENEVOLENT FUND****(Directorate of State Lotteries)****ESTIMATE OF EXPENDITURE****(For Private Accredited Hospitals only)**

(To be issued by the Private accredited hospitals to the patients proposed to undergo treatment at the hospital for the procedures allowed to the hospital concerned as per MOU signed with KBF)

1. Hospital Code:
2. Name & Address of the Hospital:
3. Name of Patient : Sex: M/F Age:
4. Address : (as per hospital records)
- i. House Name/No. : ii. Place/Village:
- iii. Grama Panchayat/Municipality/Corporation:
- iv. Post Office: PIN:
- v. Taluk: vi. District:
5. Name of Father/Mother/Husband:
6. Registration No. / I P No. : Date :
7. Diagnosis:
8. Proposed date for Operation:
9. Priority of treatment/Operation: Emergency / within 3 months/within 3 to 6 months
10. Approximate period of treatment required:
11. A. Appro. expenditure for treatment: (Give corresponding code mentioned in the Package)
- i.  ii.  iii.  iv.  v.
- vi.  vii.  viii.  ix.  x.
- B. Procedures/treatments involving medicines alone (Give corresponding code from Drugs list)
- i.  ii.  iii.  iv.  v.
- Total Estimated expenditure : Rs.
12. If the patient is eligible for financial assistance for the proposed treatment from any State/Central Govt. scheme please give details:

Name of scheme:

Eligible Amount: Rs.

13. Remarks if any-

Signature  
Name & Designation  
of the Consulting Doctor

(Seal)

Signature  
Name & Designation  
Head of the Hospital/Authorized signatory