Form No.KBF- 6A

KARUNYA BENEVOLENT FUND

(Directorate of State Lotteries)

CLAIM CERTIFICATE

(To be submitted by the Accredited Hospital along with bills for claiming treatment expenses of KBF beneficiary authorized to undergo treatment at the Hospital)

Dist Code [ ] Hospital Code [ ] Authorisation No. & Date [ ]

Authorised Amount: [ ] Admn. date [ ] Discharge date: [ ]

Amount Claimed [ ]

1. Certified that the amount claimed in the bill was actually incurred for the treatment of

   Shri/Smt. .... ……………………………………………………………………..……..

   S/o, D/o, W/o Shri/Smt. …………………………………………………… Aged: …..…….....

   (Address) .... ……………

   ……………………………………………………… who was under treatment in the Hospital

   from .... to ……………….. for .... ……...........................disease

   and the hospital has carried out the treatments vide package No (s) mentioned below.

   i. [ ] ii. [ ] iii. [ ]

   iv. [ ] v. [ ] vi. [ ]

   vii. [ ] viii. [ ]

2. Certified that all the above Treatment Packages have been carried out with utmost care and keeping accepted standards.
3. Certified that the amount claimed in the bill was partial, since the patient has been referred for adjuvant treatment at …………………………………………………….………… ……..Hospital from ………………
4. Certified that all records related to the treatment were kept under safe custody and will be made available as & when required by KBF / authorized Audit team.
5. Declaration in Form No. KBF-6B duly signed by the patient have been collected and attached with this certificate.

Signature

Name of the Consulting Doctor

Signature

Name & Designation
Head of the Hospital/Authorised person

Place:

Date:

(Office Seal)

* Score out which is not applicable