Declaration cum Consent Form

Comprehensive Cashless Health Facility Scheme

Hospital Name:_____

Hospital Address:_____

Hospital CCHF ID:_____

DECLARATION OF CCHF BENEFICIARY

I _____ son / daughter / husband / wife of Shri / Smt _____hereby declare and confirm that I am an eligible Beneficiary of Comprehensive Cashless Health Facility Scheme. My (CCHF) ID is _____ My details are: -

1. Beneficiary Name : _____
2. Gender :_____3. Date of Birth:_____
4. Permanent Address :_____
5. Contact Number :_____6. E-mail address:_____
7. Aadhar Number :_____

- I am an eligible beneficiary of Comprehensive Cashless Health Facility Scheme (CCHF). I am willing to pay all the extra charges as I have availed superior services over and above my entitlement under Comprehensive Cashless Health Facility Scheme (CCHF).
- I am fully aware and responsible for any legal or medical issues, if any, arising out of this treatment.
- I confirm that the information provided above is accurate and true to the best of my knowledge and belief.
- I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

Signatures:

- Beneficiary's / Relative's Signature : _____
  *In case of emergency, signature of beneficiary's immediate blood relation along with Aadhar card copy to be attached.
- Date : _____
- Signature of Witness: _____
- Name of Witness: _____

For Empanelled hospitals use only:

- Verification completed by hospital staff – Name and Signatures with ID Proof.
  _____
- Medical Coordinator (not less than MBBS - Name and Signature with ID Proof)
  _____
- Date of verification : _____

  **Verification is responsibility of Hospital