

MEDICAL AID SPECIAL SCHEME APPLICATION FORM (MASS)

Case NO 0004.

- A. Please read the terms & conditions carefully before filling this form
- B. Submit the Application duly filled up & signed. Please don't leave any column blank.
- C. Following documents are to be submitted with the application:- (5 enclosures)
  - i. Recent photo of patient to be pasted on the form above.
  - ii. Proof of ID & residence, of patient
  - iii. Copies of latest diagnosis / prognosis, (Kindly do not send the previous/old prescriptions.)
  - iv. Copies of latest test reports, revealing the current medical condition of patient
  - v. Attending doctors comprehensive report, showing medical condition and line of treatment / procedures proposed to be carried out & the total cost of treatment. ( Expected treatment expenditure or package cost if any, duly certified by attending doctor/s / hospital administration / relevant hospital authority

**1) PATIENT DATA**

A. PATIENT NAME KAMELA KHATUN AGE: 13 SEX F.

B. ADDRESS SIMARIA HAJI MEHRULLA TOLA.  
SIMARIA, KORHA KATIHAH BIHAR.  
854106.

C. CONTACT: TEL NO \_\_\_\_\_ MOB. NO. 9103813746 -Emergency No \_\_\_\_\_  
E-MAIL \_\_\_\_\_

D. OCCUPATION —

E. EMPLOYER —

YEARS WORKING WITH PRESENT EMPLOYER : \_\_\_\_\_ TOTAL YEARS WORKING \_\_\_\_\_

F. MONTHLY INCOME (OF PATIENT): \_\_\_\_\_  
TOTAL FAMILY MONTHLY INCOME : —

G. DIAGNOSIS

**2) FAMILY DATA**

A. FATHER'S NAME Akhtar Alam .

B. SPOUSE NAME NUKSEDA .

C. FATHERS / HUSBANDS OCCUPATION: \_\_\_\_\_

D. DETAILS OF FAMILY MEMBERS: Father Separated  
Mother Yes  
Spouse Unmarried  
Children : Boys \_\_\_\_\_ Girls \_\_\_\_\_ Total \_\_\_\_\_

E. BPL CERTIFICATE, IF AVAILABLE Not available

F. DOCUMENTS REQUIRED FROM TREATING INSTITUTION: (3 enclosures)

1. DIAGNOSIS. Facial cleft (L) & cleft palate JACHS treatment w/rt brach

2. TREATMENT PROCEDURE lip reconstruction (stages) and cleft palate repair

3. TOTAL ESTIMATED COST OF TREATMENT 2 lakh.

(Subject to terms & conditions overleaf)

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**3) CONTACT PERSONS DETAILS**

(SHOULD BE PREFERABLY A FAMILY MEMBER WHO CAN CO-ORDINATE WITH BNCT ON DAY TO DAY BASIS)

A. CONTACT PERSON NAME NURSEDA.  
B. RELATIONSHIP WITH PATIENT: MOTHER.  
C. ADDRESS BAIJHATH POK. SIMARIA.  
KORHA KATIHAK.  
D. CONTACT: TEL NO \_\_\_\_\_ MOB. NO. 9103813746.  
E-MAIL \_\_\_\_\_

**4) FINANCIAL ASSISTANCE DETAILS**

A. EXPENSES: TWO LACS.  
B. EXPENDITURE ON MEDICINES REQUIRED: TWENTY THOUSAND.  
C. DATE BY WHICH THE FUNDS ARE REQUIRED \_\_\_\_\_

**5) TO BE FILLED BY BNCT:**

- A. DOCUMENTS CHECKED AS PER LIST: YES/ NO
- B. REQUIRMENT OF MASS HAVE BEEN MET: YES/NO
- C. INSPECTION TEAM FOUND SUITABLE FOR MASS: YES/ NO
- D. APPROVAL REQUIRED FOR RELEASE OF RS \_\_\_\_\_

SIGNED (MASS TEAM) 1. Mangalrajput 01/11/25 2. Nenu 01/11/2025 3. [Signature] 01/11/25

**Declaration By Patient / Relatives**

I/We hereby declare that the information given by me/us above is true to the best of my knowledge.  
Presently I/we am/are not in a position to arrange funds for the medical emergency stated above.  
I / we have read the above terms & conditions and the same are understood by me/us.  
We confirm the acceptance of these terms & conditions.  
(The nomenclature "we" includes the patient, his family, friends, relations who are coordinating with BNCT)



Signature of Patient / Family Member

Name: NURSEDA  
RELATIONSHIP WITH PATIENT: MOTHER.  
DATE: 29/10/25.

(Subject to terms & conditions overleaf)