APPLICATION FORM FOR MEDICAL ADVANCE (BSNL)

1. Name of Patient:
2. Relationship with Employee:
3. Age:
4. Nature of Disease (for which hospitalization is required)

:

5. Name of Hospital:
6. Name of Employee:
7. Designation:
8. Salary (Basic Pay + DA). Pension:
9. Basic Pay:
10. Estimated cost of Treatment
    (Enclose original copy of Hospital's Estimate):
11. Amount of Advance required for Treatment:

Signature:
Designation:
Section:
Tel.No.

AUTHORISATION LETTER FOR TREATMENT IN HOSPITAL

This is to Certify that Shri/Smt.________________________________ (Name of the patient), age_____ is the Husband/Wife/Son/Daughter/Mother/Father of Shri/Smt___________________ an employee of BSNL. He/she may be admitted in (Hospital's Name) __________________________ as per his/her room entitlement i.e., ____

He/She may be charged as per agreed rates with BSNL.
Bills as per agreed rates may be sent to this Office for payment.

(Signature of the Competent Authority)