

KARUNYA BENEVOLENT FUND

(Directorate of State Lotteries)

ESTIMATE OF EXPENDITURE

(To be obtained from the consulting Doctor & countersigned by the authorized person of the Hospital concerned and submitted along with the application for financial assistance under Karunya Benevolent Fund)

1. Name & Address of the Hospital:
2. Name of Patient :
3. 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:
4. Age: 5. Name of Father/Mother/Husband:
6. Registration No. / IP 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. Approximate expenditure for –
 - a. Investigations Rs. b. Drugs Rs.
 - c. Surgery Rs. d. Chemotherapy Rs.
 - e. Radiotherapy Rs. f. Hospital stay Rs.
 - g. Supportive care Rs. h. Other items Rs.

Total Estimated expenditure : Rs.
12. Whether the patient has availed / proposed to avail any financial assistance from State /Central Govt. If so please give details:
13. Remarks:

Signature
Name & Designation
of the Consulting Doctor

Signature
Name & Designation
Head of the Hospital/Authorized signatory

Date (Office seal)

Details of Hospital's Bank A/c to which the Amount is to be transfer credited

A/c No.

Name of Bank

IFSC Code