



**Atal Amrit Abhiyan**  
(A Pioneering State wide Health Assurance Scheme)  
Department of Health & Family Welfare  
Government of Assam

Please affix  
photograph of the  
patient  
(Attested by  
Doctor)

**Manual Application Form \***

1.	Name of the Patient (in Block Letters)	:	
2.	Age	:	
3.	Gender	:	
4.	Father's/Guardian's Name	:	
5.	Permanent address	:	House No:  Village:  Post Office:  Police Station:  District:  Pin Code:
6.	Present Address	:	House No:  Village:  Post Office:  Police Station:  District:  Pin Code:
7.	Mobile Number	:	
8.	Annual Income of the Family	:	Rs.

**\* This application form is valid till 31<sup>st</sup> March 2017.**

9.	If the Application is not submitted by the patient	:	Name of the Applicant: Relationship with the patient: Address:  Contact No:		
10.	Disease for which Treatment is required (Please tick ✓ in the appropriate box) (Only 436 procedures of these disease groups shall be applicable)	:	Cardiovascular disease		Cancer
			Kidney Diseases		Neo Natal Diseases
			Neurological Conditions		Burns
11.	Name of Hospital where the treatment received	:			
12.	Total cost incurred in the treatment	:	Rs.		

### Declaration

*I declare that the information and documents given are correct and complete in all respects and that I have not claimed the same amount from any other Scheme/Insurance.*

Date:

Signature of the Applicant/Patient

### Documents to be submitted along with the application

		Please tick ✓
1.	Photograph of the Patient (Attested by Doctor)	<input type="checkbox"/>
2.	Annual Income Certificate issued by Circle Officer (Attested copy of the certificate to be enclosed along with the application)	<input type="checkbox"/>
3.	Attested copy of the Voter ID or Voter ID of Parent	<input type="checkbox"/>
4.	Attested copy of the Referral Certificate/ Discharge certificate & Prescription from the hospital	<input type="checkbox"/>
5.	Original copy of the Bills attested by the treating hospital (Only empanelled hospital under Assam Arogya Nidhi)	<input type="checkbox"/>

**The Filled in application form is to be submitted, by hand or by post, to the Office of the Joint Director of Health Services of the concerned district.**