

## **CONTENTS, PROCEDURES, DOCUMENTS & FORMATS**

(All contents were extracted from the FPIS Manual, October 2013)

- Documents required for claim under Family Planning Indemnity Scheme for failure Sterilization.
- All documents has to be checked by QAC/CMO/CDMO/CMHO/DMO/DHO/Joint Director designated for this purpose at **District level** before forwarding to the SQAC.
- Documents should **arrange and attach** accordingly as shown below:

*Front:-* 1. Letter of submission from QAC/CMO/CDMO/CMHO/DMO/DHO/Joint Director designated for this purpose at District level.

2. Minutes/Reports of DQAC with attendant's signature.
3. Claim Form (in original).
4. Medical Certificate (in original).
5. Application Cum Consent form for Sterilization application.
6. Sterilization Certificate.
7. Other documents supporting Sterilization done.
8. Diagnostic Report issued for failure of Sterilization.

*Back:-* 9. Other documents:

Example -Admission slip, Bed Head ticket, Discharge slip, Birth Certificate etc. which are supporting failure of Sterilization.

### **Operationalization of Procedure for Claim Settlement:**

1. Claim Form required for submitting claims under FPIS should be made available with all medical facilities conducting Sterilization procedures.
2. Medical Certificate (in a prescribed format) issued by QAC/CMO/CDMO/CMHO/DMO/DHO/Joint Director designated for this purpose at District level should be made available.
3. On receipt the information of any Claim from the acceptor of Sterilization under section I, the beneficiary through their designated hospital and Doctors, shall immediately fill up Claim Form.
4. The Claim Form Cum Medical Certificate in original shall be duly completed in all respects by the beneficiary submitted through their designated hospital and Doctors.
5. The Claimant's name under section I-C & I-D shall be in the name of beneficiary.
6. On receiving the Claim papers, proper acknowledgement must be made by the designated district official by putting the signature and stamp on all documents for further processing and payment of the claims.
7. The "Claim Form Cum Medical Certificate" in original after completion in all respect should be authenticated by the QAC/CMO/CDMO/CMHO/DMO/DHO/Joint Director designated for this purpose at District level.
8. The processing should be done by the DQAC to put up to SQAC.

**DOCUMENTS REQUIRED FOR FAILURE OF STERILIZATION UNDER (SECTION I-C)**

**A.Claim Form cum Medical Certificate in original** duly signed and stamped by the convener of QAC/CMO/CDMO/CMHO/DMO/DHO/Joint Director designated for this purpose **at district level.** (Annexure-I).

**CLAIM FORM should be check:**

1. Claim is submitted in a prescribed Claim Form in original.
2. Claim forwarded through Medical Officer/Health Facility conducting sterilization procedures.
3. Name and address of the acceptor are **same mentioned on Consent form.**
4. Signature or thumb impression of acceptor is **same as mentioned on Consent form.**
5. Date of sterilization is **same as mentioned in the Sterilization Certificate and Consent form.**
6. Other details filled in are tallied with other relevant documents which are becoming part of claim form.
7. All columns of Medical Certificate which is a part of Claim Form are filled in and date, Signature and seal of CMO or Equivalent designated for this purpose **at district level** has been placed.

**B. Copy of Consent Form duly attested by QAC/CMO/CDMO/CMHO/DMO/DHO/Joint Director** designated for this purpose **at district level.**(Annexure-II).

**CONSENT FORM should be check:**

1. Registration number of the beneficiary, date, and signature or thumb impression of the beneficiary are properly placed in respective columns.
2. Examination of patient record is filled in properly and doctor has put his signature and date.
3. Details of dependents of a beneficiary are filled in.
4. All columns of Consent form and Medical Record & Check List for female / male Sterilization are filled properly.

**C. Copy of Sterilization Certificate duly attested** by the convener of QAC/CMO/CDMO/CMHO/DMO/DHO/Joint Director designated for this purpose **at district level.**(Annexure-IV).

**STERILIZATION CERTIFICATE should be check:**

1. Name of beneficiary is same as filled in on Consent form.
2. Date of sterilization is mentioned **under specific column.**
3. Certificate issued has **signature and date** of issuing authority.
4. Sterilization Certificate is in **proper format** as prescribed by the State and having **Registration Number and date.**

**D. Copy of any of the following Diagnostic Reports confirming failure of Sterilization duly attested** by the convener of QAC/CMO/CDMO/CMHO/DMO/DHO/Joint Director designated for this purpose **at district level.**

**DIAGNOSTIC REPORT ISSUED FOR FAILURE OF STERILIZATION should be**

**check**

1. Report issued should be in a proper document i.e. hospital case sheet/ proper diagnostic report.
2. It should have **registration number and date**.
3. Cause detected for failure has been properly recorded by the issuing authority on the document.
4. First diagnostic report by which a failure is detected is attached.

a). In case of Tubectomy the report may be:

1. Urine test report supported by physical examination report / ANC/USG report.
2. MTP report.
3. Physical examination report.
4. USG report
5. In extreme cases Birth Certificate in case of full term pregnancy.

***Birth Certificate should be check:***

1. Issued on a proper format.
2. Name of the acceptor tallies with other records.
3. Date of birth has been properly recorded.
4. The certificate is signed and duly stamped with date by proper authority.

b). In case of Vasectomy:

1. Semen test report.

**NOTE: ANY ONE** of the above (a) / (b) documents detecting failure of Sterilization would be sufficient for processing the Claim under this section.

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**Please follow strictly according to these Formats enclosed herewith as per FPIS Manual, October 2013**

<b>Claim form</b>	<b>Medical Certificate</b>	<b>Application Cum Consent form</b>	<b>Format for those who cannot Read / Write</b>	<b>Sterilization Certificate</b>
Page: 4 & 5	Page: 6	Page: 7 & 8	Page: 9	Page: 10

***\*Please refer to the FPIS manual, October 2013 for more details.***

### CLAIM FORM FOR FAMILY PLANNING INDEMNITY SCHEME

The State will ensure that Claim Form cum Medical Certificate required for submitting claims under the FPIS Scheme are made available with all medical facilities conducting sterilization procedures, Office of CMO/CDMO/CMHO/CDHMO/DMO/DHO/Joint Director designated for this purpose at district level etc. in local language along with their English version.

1. This form is required to be completed for lodging claim under Section-I of the scheme.
2. This form is issued without admission of liability and must be completed and returned to The District Health Society/State Health Society for processing of claim.
3. **No claim can be admitted unless certified by the convener of QAC/CMO/CDMO/CMHO/CDHMO/DMO/DHO/JOINT DIRECTOR designated for this purpose at district level by the State Government.**

**Claim no. :** \_\_\_\_\_

**1. Details of the Claimant:**

Name in full: \_\_\_\_\_ Present Age: \_\_\_\_\_ Years

Relationship with the acceptor of Sterilization: \_\_\_\_\_

Residential Address:

\_\_\_\_\_

\_\_\_\_\_ Telephone no. \_\_\_\_\_

**2. Details of the person undergone sterilization operation:**

Name in Full: \_\_\_\_\_ Age: \_\_\_\_\_ Years

Son /daughter of: \_\_\_\_\_

Name of the Spouse: \_\_\_\_\_ Age of the Spouse: \_\_\_\_\_ Years

Address: \_\_\_\_\_

**3. Permanent Business or Occupation:** \_\_\_\_\_

**4. Details of Dependent children:**

Sl. No.	Name	Age (Yrs)	Sex (M/F)	Whether Unmarried	If unmarried, Whether dependent

**5. (a) Date of Sterilization Operation:** \_\_\_\_\_

**(b) Nature of Sterilization operation:**

(i). Laparoscopic Tubectomy: \_\_\_\_\_

(ii) Vasectomy: \_\_\_\_\_

(iii) MTP followed by sterilization: \_\_\_\_\_

(iv) Caesarean operation followed by Sterilization: \_\_\_\_\_

(v) Any other surgery followed by Sterilization: \_\_\_\_\_

**6.(a) Name and address of the doctor who conducted the operation:**

\_\_\_\_\_

**(b) Name and address of the hospital where operation was conducted:**

\_\_\_\_\_

**(c) Nature of claim:**

**1) Failure of Sterilization** not leading to child birth: \_\_\_\_\_

**2) Failure of Sterilization** leading to child birth: \_\_\_\_\_

**3) Medical Complication** due to Sterilization (state exact nature of complication):

a. Date: \_\_\_\_\_

b. Details of Complication: \_\_\_\_\_

c. Doctor /Health facility: \_\_\_\_\_

**d)Death followingSterilization:**

a. Date of Admission: \_\_\_\_\_ Time: \_\_\_\_\_

b. Date of Discharge: \_\_\_\_\_ Time: \_\_\_\_\_

c. Date of Death: \_\_\_\_\_ Time: \_\_\_\_\_

**7. Give details of any disease suffered by beneficiary prior to undergoing sterilization operation:**

\_\_\_\_\_

I HEREBY DECLARE that the particulars are true to the best of my knowledge and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or shall make any false or untrue statement, suppression or concealment of fact, my right to the compensation shall be absolutely forfeited.

I hereby claim a sum of Rs. \_\_\_\_\_/- under the scheme, which I agree in full settlement of my claim and shall have no further right whatsoever to claim under the scheme.

**Date:** \_\_\_\_\_ **Name of Acceptor/Claimant:** \_\_\_\_\_

**Place:** \_\_\_\_\_ **Signature (in full) or thumb impression**

**MEDICAL CERTIFICATE ISSUED BY CMO/CDMO/CMHO/CDHMO/DMO/DHO/JOINT  
DIRECTOR DESIGNATED FOR THIS PURPOSE AT DISTRICT LEVEL**

It is certified that Smt/Shri. \_\_\_\_\_ S/o/W/o: \_\_\_\_\_  
\_\_\_\_\_ R/o \_\_\_\_\_

had undergone sterilization operation on \_\_\_\_\_ at \_\_\_\_\_  
(hospital) and conducted by Dr. \_\_\_\_\_ Qualifications \_\_\_\_\_  
\_\_\_\_\_ posted at \_\_\_\_\_

**Nature of Sterilization operation done:**

- (i) Laparoscopic Tubectomy: \_\_\_\_\_
- (ii) Vasectomy: \_\_\_\_\_
- (iii) MTP followed by Sterilization: \_\_\_\_\_
- (iv) Caesarean operation followed by Sterilization: \_\_\_\_\_
- (v) Any other surgery followed by Sterilization: \_\_\_\_\_

**I have examined all the medical records and documents and hereby conclude that the sterilization operation is the antecedent cause of:**

- 1) Failure of Sterilization** not leading to child birth: (\_\_\_\_\_) (attach documentary evidence)
- 2) Failure of Sterilization** leading to child birth: (\_\_\_\_\_) (attach documentary evidence)
- 3) Medical Complication** due to Sterilization (please give the details as under):

- (i). Nature of Complication: \_\_\_\_\_
- (ii). Period: \_\_\_\_\_
- (iii). Expenses incurred for treatment of complication Rs. \_\_\_\_\_ (**Attach**

**original Bills/Receipts/Prescriptions).**

- d) Death of Person (cause):** \_\_\_\_\_
- a. Date of Admission: \_\_\_\_\_ Time: \_\_\_\_\_
- b. Date of Discharge: \_\_\_\_\_ Time: \_\_\_\_\_
- c. Date of Death: \_\_\_\_\_ Time: \_\_\_\_\_

I have further examined all the particulars stated in the claim form and are in conformity with my findings and is eligible for a compensation of Rs..... due to.....(Cause). **Please pay Rs \_\_\_\_\_ to the beneficiary.**

**Documents Enclosed:**

- (a) Original Claim cum Medical certificate ( )
- (b) Attested copy of sterilization certificate ( )
- (c) Attested copy of consent form ( )
- (d) \_\_\_\_\_ ( )
- (e) \_\_\_\_\_ ( )

**Date:** \_\_\_\_\_ **Seal:** \_\_\_\_\_  
**Name** \_\_\_\_\_ **Designation** \_\_\_\_\_  
**Tel/Mob. No.** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Annexure-II**

## APPLICATION CUM CONSENT FORM FOR STERILIZATION OPERATION

An informed consent is to be taken from all acceptors of sterilization before the performance of the surgery as per the consent form placed below

**Name of Health Facility** .....

**Beneficiary Hospital Registration Number:** ..... **Date:** ...../...../20.....

**1. Name of the Acceptor:** Shri/Smt. ....

**2. Name of Husband/Wife:** Shri/Smt. ....

**Address** .....

**Contact No:** .....

### **3. Names of all living, unmarried dependent Children**

i) ..... Age.....

ii) ..... Age.....

iii) ..... Age.....

iv) ..... Age.....

**4. Father's Name of beneficiary:** Shri.....

**Address:** .....

**5. Religion/Nationality:** .....

**6. Educational Qualifications** .....

**7. Business/Occupation:** .....

**8. Operating Centre:** .....

I, Smt/Shri ..... (client) hereby give consent for my sterilization operation. I am ever married. My age is ..... **years** and my husband/wife's age is ..... **years**. I have ..... (Nos.) male and ..... (Nos.) female living children. The age of my youngest living child is ..... years.

**# I am aware that I have the option of deciding against the sterilization procedure at any time without sacrificing my rights to other reproductive health services.**

a) I have decided to undergo the sterilization / re-sterilization operation on my own without any outside pressure, inducement or force. I declare that I / my spouse has not been sterilized previously **(not applicable in case of re-sterilization)**. (....)

b) I am aware that other methods of contraception are available to me. I know that for all practical purposes this operation is permanent and I also know that there are still some chances of failure of the operation for which the operating doctor and health facility will not be held responsible by me or by my relatives or any other person whomsoever (....)

c) I am aware that I am undergoing an operation, which carries an element of risk. (....)

d) The eligibility criteria for the operation have been explained to me, and I affirm that I am eligible to undergo the operation according to the criteria. (....)

e) I agree to undergo the operation under any type of anaesthesia, which the doctor/health facility thinks suitable for me and to be given other medicines as considered appropriate by the doctor/health facility concerned. (....)

f) If, after the sterilization operation, I experience a missed menstrual cycle, then I shall report within two weeks of the missed menstrual cycle to the doctor/health facility and may avail of the facility to get an MTP done free of cost. (....)

**g) In case of complications following sterilization operation, including failure, and the unlikely event of death following sterilization, I/my spouse and dependent unmarried children will accept the compensation as per the existing provisions of the Government of India “Family Planning Indemnity Scheme” as full and final settlement and will not be entitled to claim any compensation over and above the compensation offered under the “Family Planning Indemnity Scheme” from any court of law in this regard or any other compensation for upbringing of the child. (....)**

h) I agree to come for follow-up visits to the Hospital/Institution/Doctor/health facility as instructed, failing which I shall be responsible for the consequences, if any. (....)

i) I understand that Vasectomy does not result in immediate sterilization. \*I agree to come for semen analysis **3 months after the operation** to confirm the success of sterilization surgery (Azoospermia) failing which I shall be responsible for the consequences, if any. (....)

**(\*Applicable for male sterilization cases)**

**I have read the above information.**

**#The above information has been read out and explained to me in my own language and that this form has the authority of a legal document.**

**Date:** .....

**Signature or Thumb Impression of the Client  
Name of acceptor:**

.....

**Signature of Witness (Acceptors side):**

**Full Name:** .....

**Signature of Witness**.....

**Full Address**.....



# (This format is applicable only for those beneficiaries who cannot read and write)

Applicable to cases where the client cannot read and the above information is read out.

Shri/Smt ..... has read/have been fully explained about the contents of the informed Consent Form in his/her local language.

Signature of Counsellor: .....

Full Name: .....

Date: ..... Full Address.....

I certify that I have satisfied myself that –

a. Shri/Smt..... is within the eligible age-group and is medically fit for the sterilization operation.

b. I have explained all clauses to the client and that this form has the authority of a legal document.

c. I have filled the Medical record–cum-checklist and followed the standards for sterilization procedures laid down by the Government of India.

Signature of Operating Doctor

Signature of Medical Officer in-charge of the Facility

(Name of Operating Doctor)

(Name of Medical Officer in-charge of the Facility)

Date: .....

Date: .....

Seal

Seal

**DENIAL OF STERILIZATION**

I certify that Shri/Smt.....is not a suitable client for sterilization/re-sterilization for the following reasons:

- 1. ....
- 2. ....

He/She has been advised the following alternative methods of contraception.

- 1. ....
- 2. ....

**Signature of the Counsellor\*\* or Doctor making the decision**

Date: .....Name and full Address: .....

(\*\* Counsellor can be any health personnel including doctor)

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**Annexure-III**

**MEDICAL RECORDS & CHECK LIST FOR FEMALE / MALE STERILIZATION** (to be filled before commencing the operation)

A checklist to be filled by the doctor before conducting sterilization procedure for ensuring the eligibility and fitness of the acceptor for sterilization. This annexure is a part of Consent form. (Annexure-III)

Please follow the instruction from the FPIS Manual, October-2013, Page 27-29

**STERILIZATION CERTIFICATE**

Reg P.No

Sl. No.

Year

This is to certify that Smt/Shri ..... (Hosp.No.) .....  
S/o/W/o. Sri: ..... (He/She is working as .....  
residing at ..... has undergone  
Vasectomy/Tubectomy operation in ..... (name of the  
facility/hospital) on .....  
Sperm count was undertaken on ..... and on the basis  
thereof it is certified that the Vasectomy operation has been completely successful.

(Para 2 inly in case of Vasectomy operation only)

**Signature**

**Medical Officer**

**Name.....**

**Date .....**

**Seal .....**