FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND OR TREATMENT OF CENTRAL GOVT. SERVANTS AND THEIR FAMILIES

N. B. :- Separate Form should be used for each Patient.

1. Name and Designation of the Govt. Servant
   (i) Whether married or unmarried
   (ii) If married the place where wife/husband is employed

2. Office in which employed

3. Pay of the Government Servant as defined in the Fundamental Rules, and any other emoluments, which should be shown separately.
   Pay
   D. A.
   H. R.
   C. C. A.

4. Place of duty

5. Actual residential address

6. Name of the patient and his/her relationship to the Govt. Servant

   N. B. :- In the case of children state age also

7. Place at which the patient fell ill

8. Details of the amount claimed :-

   I. MEDICAL ATTENDANCE

(i) Fees for consultation, indicating :

   (a) The name and designation of the medical officer consulted and the hospital or dispensary to which attached.

   (b) The number and dates of consultations and the fee paid for each consultation.

   (c) The number and dates of injections and the fee paid for each injection.

   (d) Whether consultations and/or injections were had at the hospital, at the consulting room of the medical officer or at the residence of the patient.

(ii) Charges for pathological, bacteriological, radiological or other similar tests undertaken during diagnosis, indicating, :-

   (a) The name of the hospital or laboratory where the tests were undertaken, and

   (b) Whether the tests were undertaken on the advice of the authorised medical attendant. If so, a Certificate to that effect should be attached.

(iii) Costs of medicines purchased from the market.

(List of medicines, cash memos and the Essentiality Certificates should be attached) (P.T.O.)

9. (a) Total amount claimed

(b) Less amount of advance taken on

(c) Net amount claimed

10. List of enclosures :-

(i) Prescription :-

(ii) OPD Slips :-

(iii) Certificate :- A :

(iv) Cash Memo(s)

	No. and date	Amount	Name of the Shop
(i)			
(ii)			
(iii)			
(iv)			
(v)			

Declaration to be signed by the Govt. Servant

I hereby declare that the statements in this application are true to the best of my knowledge and that the person for whom medical expenses were incurred is wholly dependent upon me.

Certified that there is no Govt. Fair Price Shop/Co-operative Consumers' Stores/Drug Depots run by the Central or State Govt. or Local bodies or any other organisation under the Co-operative Societies Act, within two kilometers radius from my residence.

Date _____

Signature of the Govt. Servant

Claim passed for payment

for Rs. _____

Amount Claimed Rs. _____

Less Amount disallowed Rs. _____

Net Amount Rs. _____

Admitted for reimbursement _____

दावा राशि का भुगतान / Claim Passed for Payment of Rs. ...../- In Words (.....

कनिष्ठ सहायक अनुभाग अधिकारी उप- कुलसचिव कुलसचिव

Med. 103

Certificate granted to Mrs. / Mr. / Miss _____

Wife / Son / Daughter of Shri / Smt. _____

_____

CERTIFICATE 'B'

[to be completed in the case of patients who are admitted to hospital for treatment]

PART A

[To be signed by the Medical Officer-in-charge of the _____ case of the hospital]

I, Dr. _____ hereby certify :—

(a) that the patient was admitted to hospital $\frac{\text{on the advice of}}{\text{on my advice}}$

_____

Name of the Medical Officer

(b) that the patient has been under treatment at _____ and that the undermentioned medicines prescribed by me in this connection were essential for the recovery / prevention of serious deterioration in the condition of the patient. The medicines are not stock in the

_____

Name of Hospital

for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants.

S. No.	Name of Medicines	Price Rs.	P.
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			

P.T.O.

(c) that the injections administered $\frac{\text{were}}{\text{were not}}$ for immunising or prophylactic purposes.

(d) that the patient is / was suffering from_____

and is / was under treatment from_____to_____

(e) that the X-ray, laboratory tests, etc., for which an expenditure of Rs._____was incurred were necessary and were undertaken on my advice at_____

(Name of Hospital or Laboratory)

(f) that I called on Dr. _____for special consultation and that the necessary approval of the_____

(Name of the Chief Administrative Medical Officer of the State)

_____as required under the Rules, was obtained.

Signature and Designation of the Medical Officer-in-charge of the case at tha Hospital

PART B

I certify that the patient has been under treatment at the_____ hospital and that the service of the special nurses, for which an expenditure of Rs._____was incurred **vide** bills and receipts attached, were essential for the recovery / prevention of serious deterioration in the condition of the patient.

Signature of the Medical Officer-in-Charge of the case at the Hospital

COUNTERSIGNED
Medical Superintendent

_____Hospital

* I Certify that the patient has been under treatment at the_____hospital and the facilities provided were the minimum which were essential for the patient's treatment.

Place_____ Medical Superintendent

_____Hospital

N.B.—Certificates not applicable should be struck off. Certificate (D) is compulsory and must be filled in by the Medical Officer-in-charge of the case.

* The minimum facilities certificate may be signed either by the Medical Superintendent of the Hospital concerned or another Gazetted Officer who has been authorised in this behalf by the Medical Superintendent.

(163) Letterprint. Bom-2/Hyd-1/Ahm-1/VP (P) 8m 010287