**FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURED IN CONNECTION WITH MEDICAL ATTENDANCE AND ON TREATMENT OF CENTRAL GOVERNMENT SERVANT AND THEIR FAMILY.**

**N.B. Separate form should be used for each patient.**

1. Name and designation of the Govt. Servant :

 (In Block Letter)

2. Office in which attached :

3. Pay of the Govt. Servant defined in :

 The fundamental rules and any other

Emoluments shown separately

4. Place of duty :

5. Actual Residential address :

6. Name of the patient and his/her :

 relationship with the Govt. Servant

7. Place at which the patient fell ill :

8. Details of the amount claimed :

(I) MEDICAL ATTENDANCE

(a) The name and designation the Medical :

 Officer consulted and the Hospital or

 Dispensary to which attached

(b) The number and dates of injection and :

 The fee paid for each consultation.

(c) The number and dates of injection and :

 The fee paid for each injection.

(d) Whether consultation and / or injection :

 were had at the hospital at the consulting

 room of the Medical Officer or at the

 residence of the patient.

9. Total amount claimed :

10. List of enclosures :

....................................................................................................................................................

DECLARATION TO BE SIGNED BY GOVERNMENT SERVANT

....................................................................................................................................................

 I do hereby declare that the statement given in the application is true to the best of my knowledge and belief that the person for whom medical expenses were incurred is wholly dependent upon me.

Date: ...................... Signature of Govt. Servant

 And office to which attached

**C E R T I F I C A T E ‘A’**

(To be completed in the case of patients who are not admitted to hospital for treatment)

Certificate granted to Mr/Mrs/Miss ..................................................................... wife/son/daughter of Mr.................................................. employed in the.............................................................................

I, Dr. .......................................................................................hereby certify (a) that I charged and received Rs......................................... or ........................................................................... consultation

on...........................................(Dates) at my consulting room/at the residence of the patient.

(b) That I charged and received Rs.........................................................for administrating..................................................... Intra-venous/Intra Muscular/Subtance-ous injection on....................................................... (Date) at my consulting room/ the residence of the patient.

(c) That injection administered was not/were for immunizing or prophylactic purposes.

|  |  |  |  |
| --- | --- | --- | --- |
| Sl.No. | Name of the medicines Price(In Capital letter) | Quantity | Amount (Price) |
| 1. |  |  |  |
| 2. |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |
| 7 |  |  |  |
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| 9 |  |  |  |
| 10 |  |  |  |
| 11 |  |  |  |
| 12 |  |  |  |
| 13 |  |  |  |
| 14 |  |  |  |
|  | Grand Total |  |  |

(d) That the patient has been under treatment at...........................................................................

Hospital/my consulting room and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of service deterioration the condition of patient. The medicines are not stocked in the........................................................................... (Name) of hospital for supply to private patient and do not include proprietary preparation for which cheaper substances of equal there foods, toilets or disinfects.

(e) That the patient is/was suffering from ................................................ and was under my treatment from ..........................................to.............................................

(f) That the patient is/was given pre-natal treatment.

(g) That the X-ray, laboratory test etc. for which and expenditure on my Rs. ......................................was incurred was necessary and were under taken on my advice at ....................................................(Name of the hospital or laboratory).

(h) That I referred the patient to Dr. ..................................................................................for specialist consultation and that the necessary approval of the....................................................... (Name of the Chief Administrative Officer of the state as required under the rules was obtained).

(i) That the patient did not required hospitalisation.

Date: Signature and Designation of the

 Medical Officer and hospital

**C E R T I F I C A T E ‘B’**

(To be completed in the case of patients who are admitted to hospital for treatment)

 Certificate granted to Mrs. / Mr. / Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_wife/son/daughter of Mrs. / Mr. / Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ employed in the office of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 **PART ‘A’**

(To be signed by the Medical Officer-in-charge of the\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (in case of hospital)

I, Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby certify:-

1. That the patient was admitted to hospital on the advice of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of the medical officer / on my advice,
2. That the patient has been under treatment at \_\_\_\_\_\_\_\_\_\_\_\_\_\_ and that the under mentioned 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 stocked in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets or disinfectants.

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| --- | --- | --- |
| **Sl.no.** | **Name of Medicine** | **Price** |
| **Rs.** | **Paisa** |
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 That the injections administered were/were not for immunising or prophylactic purposes,

1. That the patient, is/was suffering from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and is / was under treatment from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. That the X-ray, laboratory tests etc. for which an expenditure of Rs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was incurred were necessary and were taken (under) on my advice at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of hospital or laboratory).
3. That I called on Dr\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for specialist 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 the 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 that the facilities provided were the minimum which were essential for the patient’s treatment.

 Medical Superintendent.

Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_\_\_\_\_\_Hospital.

N.B.:- certificates not applicable should be struck off certificates (D) is compulsory and must be medical officer in the cases \_\_\_\_\_\_\_\_\_\_\_\_

The minimum facilities certificate may be signed either by the medical superintendent of the hospital/ Gazetted medical Officer who has been authorized in this behalf by the medical superintendent.