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.

Separate form should be used for each patient.

N.S. Name and Designation of the Govt. Servant

I) Whether married or unmarried

II) If married the place where wife is Employed.

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2. Office in which employed

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3. Pay of the Government Servent as defined in the Fundamental Rules and any other emoluments which should be shown separately.

Pay
D.A.
H.R.A.

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4. Place of duty

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5. Actual Residential address

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

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

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7. Place at which the patient fell ill

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8. Details of the amount claimed

1. 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 of dates of consultation and The fee paid for each consultation

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

(d) Whether consultation and/or injection Were held 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 under taken and

(b) Whether the tests were undertaken on the advice Of the authorized medical attendant, if so a Certificate to that effect should be attached.

iii) Costs of medicine purchased from the market (List of medicines, cash memos and the essentiality certificate should be attached)

9. (a) Total amount claimed
(b) Less amount of advance taken on
(c) Net amount claimed

10. List of enclosures :

	No. and date	Amount	Name of Shop
i) Prescription	i)		
ii) CPS Slips	ii)		
iii) Certificate	iii)		
iv) Cash memo(s)	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/Cooperatives Consumer 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 radious from my residence.

Date:

Signature of the Govt. Servant

Claim passed for payment
for Rs.

Amount Claimed Rs.
Less amount disallowed Rs.
Net amount Admitted for reimbursement Rs.

(To be filled in by the applicants)

DISPOSAL OF CLAIMS UNDER THE MEDCAL ATTENDANCE RULES.

1. (a) Name of the employee .....
   Pay Rs. .....
   (b) Whether for self or family .....
   (c) If for family name of the patient and his/her relationship to the Govt. Servant. In case of children state age also. .....
2. Period for which claim has been prepared .....
3. Disease .....
4. Name of the Doctor with rank, who treated the patient .....
5. Amount claimed .....
6. (a) Medicines .....
   .....
   (b) Consultation fee .....
   (c) Injection fee .....
   (d) Blood Test .....
   (e) Ward/rent .....
   (f) X-ray, Radiological, Pathological Treatment etc. .....
   (g) Any other particulars per-Training to the claim .....
   (h) Diet charge .....
   (i) Any Specialised medical Attendance or treatment .....
7. Wheter vouchers/receipts in support of the claim have been submitted. .....
8. Whether the supporting vouchers and receipts have been counter-signed .....
9. Whether the medical treatment and attendance have been carried out in the Govt. Hospital by the AMA defined in the rules. .....

* If married, the place where .....

** wife/husband is employed .....

10. Whether certificates required under the rules have been furnished .....

11. Name of medicines claimed in the bill that are reimbursable

(a) .....
(b) .....
(c) .....
(d) .....
(e) .....
(f) .....
(g) .....

12. Admissibility of claim .....

13. Amount disallowed and reasons for disallowance .....

14. Amount admissible to the claimant .....

15. Whether special case to be made out .....

16. Net amount sanctioned for payment. .....

A.O. Jt. D A (admn) D A

YRH/20/11/98

पत्नी/पुत्र/पुत्री श्री ..... को दिया गया प्रमाण-पत्र

Certificate granted to Mrs./Mr./Miss. .....

wife/son/daughter of Mr. .....

employed in the .....

प्रमाण-पत्र 'क'
CERTIFICATE 'A'

(उन रोगियों के मामले में भरा जाए जिन्हें इलाज के लिए अस्पताल में भर्ती न किया गया हो)
(To be completed in the case of patients who are not admitted to hospital for treatment)

मैं डा. ..... प्रमाणित करता
I, Dr. ..... hereby/ce

(क) कि मैंने अपने परामर्श कक्ष में/रोगी के निवास स्थान पर (काटें दी जाएं) .....
को ..... परामर्श के लिए ..... रुपये प्राप्त किए और आज ति

(a) that I charged and received Rs. .....
consultations on ..... at my consulting room/at the residence of the patient.
(Dates to be given)

(ख) कि मैंने अपने परामर्श कक्ष में/रोगी के निवास स्थान पर (काटें दी जाएं) .....
को अन्तः पेशी/अन्तश्चर्म इंजेक्शन देने के लिए ..... रुपये प्राप्त किए और आज

(b) administering ..... intra/muscular/sub-cutaneous injections on .....
..... at my consulting room/at the residence of the
(Dates to be given)

(ग) कि दिए गए इंजेक्शन रोगप्रतिरक्षा या रोग निरोध के लिए नहीं थे ।

(c) that the injections administered were/were not for immunising or prophylactic purposes.

(घ) कि रोगी का इलाज ..... अस्पताल में/मेरे परामर्श कक्ष में किया गया है और मैंने
इस नुस्खे में दी गई निम्नलिखित औषधें रोगी की हालत को स्थिर करने/गंभीर रूप से खराब होने से रोकने के लिए अनिवार्य
औषधें ..... अस्पताल में प्रवेशित रोगियों को देने के लिए
(अस्पताल का नाम)
की जाती और उनमें से घरेलू (एकांतवास) रोगी चाहित नहीं है जिनके लिए समान चिकित्सा गुण वाले सस्ते द्रव्य उपलब्ध हैं न
जो मुख्यतः खाद्य, शृंगार सामग्री अथवा निरोधक हैं ।

(d) that the patient has been under treatment at .....
consulting room and that the undermentioned medicines prescribed by me in this connection were essent
recovery/preventions of serious deterioration in the condition of the patient. The medicines are not stocd
(name of the hospital) .....
supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeu
available nor preparations which are primarily foods, toilets or disinfectants.

क्रम सं० Sl. No.	औषधि का नाम Name of Medicines	कीमत Price रु० Rs.	पै० P.	क्रम सं० Sl. No.	औषधि का नाम Name of Medicines	कीमत Price रु० Rs.	पै० P.
1				6			
2				7			
3				8			
4				9			
5				10			

(कृ

(ङ) कि रोगी ..... से पीड़ित है/था और ..... से ..... तक मेरे इलाज में है/था ।

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

(च) कि रोगी को जच्चा पूर्व अथवा जच्चोत्तर चिकित्सा नहीं गई है/थी ।

(f) that the patient is/was not given prenatal or post-natal treatment.

(छ) कि जिन एक्सरे, प्रयोगशाला जांच आदि के लिए ..... रुपए खर्च किए गये वे आवश्यक थे ..... से किए गए थे ।

(अस्पताल या प्रयोगशाला का नाम)

(g) that X-ray, laboratory test, etc., for which an expenditure of Rs ..... was incurred were necessary and were undertaken on my advice at .....
(name of the hospital or laboratory)

(ज) कि मैंने रोगी को विशेष परामर्श के लिए जाने ..... को प ....वहां राज्य के मुख्य प्रशासनिक चिकित्सा अधिकारी म के अनुसार यथापेक्षित आवश्यक अनुमोदन प्राप्त कर लिया गया था ।

(h) that I referred the patient to Dr. .....
consultation and that the necessary approval of the .....
as required under the rules was obtained. (name of the Chief Administrative Medical O

(झ) कि रोगी को अस्पताल में रखना आवश्यक नहीं था/आवश्यक था ।

(i) that the patient did not require/required hospitalisation.

चिकित्सा अधिकारी के हस्ताक्षर और पदनाम ।
चिकित्सालय का नाम जिससे वह
Signature & Designation of the Medica
the Hospital/Dispensary to which

तारीख .....
Date

विशेष ध्यान दें :— जो प्रमाण-पत्र लागू न हों वे काट दिए जाने चाहिए । प्रमाण-पत्र (घ) अनिवार्य है और चिकित्सा अधिकारी से भरा जाना चाहिए ।

N.B.—Certificates not applicable should be struck off. Certificate (d) is compulsory and must be filled in by the Medical Officer i