

FORMS AND CERTIFICATES

APPENDIX – II

APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND TREATMENT OF GOVERNMENT SERVANT AND THEIR FAMILIES

- 1 Name and Designation & Section (in block letters) :
- 2 Office in which employee :
- 3 Pay of the Govt., servant as defined in FRs and others employments which should be shown separately :
- 4 Place of duty :
- 5 Full Residential address with door No and Name of the Mohalla :
- 6 Name of the patient, His/Her relationship to the Govt., servant. In case of children state age also :
- 7 Place at which the patient fell ill :
- 8 Nature of illness and its duration :
- 9 Details of amount claimed cost of Medicines purchased from the market/List of medicines/cash memos, and the essentiality certificate should be attached each in duplicate signed by treatment doctors :
- 10 Total amount claimed : Rs.
- 11 List of enclosures :

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT/PENSIONER

I hereby declare that the statement in this application is true to the best of my knowledge and belief and that the person from whom medical expenses were incurred is a member of my family as defined under the Government servant Medical attendance rules 1972 and wholly dependent upon me.

Signature of Govt., Servant/Pensioner
and office to which attested

CERTIFICATE – A

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

1. I Dr. Hereby certify that
- (a). I charged Rs..... for. Consultation on at my consultation room/at the residence of the patient.
 - (b). That I charged Rs.for administering intramuscular/intravenous/subcutaneous injections on (Dose to be given) at my consulting room at the residence of the patient.
 - (c). That injections administrated repay in formatting or propyloction purpose.
 - (d). That the patient has been under treatment at Hospital/Consulting room 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.. hospital and do not include proprietary preparations for which cheaper substances of equal therapeutic values are available not preparations which are primarily foods, tonics, toilets or disinfectants.

Name of the Medicine	Cost
.....
.....
.....
.....

- (e). That patient is/was suffering from and is/was under my treatment from
- (f). That the patient was/not given prentation post treatment.
- (g). That the X ray, laboratory tests etc, for which an expenditure of Rs. Was incurred was necessary and was under taken on may active at the (name of the hospital or laboratory)
- (h). That referred the patient of Dr.for specialist mutilation and that the necessary approval of Director, Medical Service as required under the rules was obtained and
- (i). That the patient did not require/required hospital etc.

Date.

Signature and Designation
Of the Authorized Medical attendant.

ESSENTIALITY CERTIFICATE

I Certify that Mrs./Mr./Misswife/son/Daughter of Mr.
 Employed in the has been under my treatment for
 Deceases from to at
 Hospital/my consulting room and that the under mentioned medicines prescribed by me in
 this connection were essential from recovery/prevention of serious deterioration the condition of the
 patient. The Medicines are not stocked in the hospital (from supply to
 patients) and do not include proprietary preparations fro which cheaper substance of equal therapeutic
 value are available or preparations which are primarily foods, toilets or disinfectants.

Name of Medicines	Price

Signature and Designation of Authorized Medical Attendant Signature of the Medical Officer In
 charge in the case of the hospital.

EMERGENCY ADMISSION CERTIFICATE

This is to certify that Mr./Mrs./Ms. S/o,D/o,W/o
 age about admitted in our hospital in
 Department under emergency on at
 Am/Pm.

The provisional diagnosis is

Signature and Designation of the
 Attending Medical Authority.