APPLICATION FOR MEDICAL REIMBURSEMENT

1. Name of the Teacher & Post and Employee Code :-==========

2. Name of School and Mandal :----------

3. Name of the Patient and his relation ship with Teacher :----------

4. Name of Disease for which Treatment/Surgery Executed :----------

5. Period of Treatment :----------

6) Name of the Hospital & RC No with which Referral status Sanctioned :----------

7. Total Amount Claimed :----------

8. List of Enclosures submitted in 1+2 Copies
a) Appendix –II ( ) b)checklist( ) c)Non drawal certificate ( )
d)Emergency certificate( ) e)Essentiality certificate( ) f)Dependence certificate ( )
g)Discharge summary( ) h) Medical bills( ) i)Operation notes ( )
j)pension order( ) k)referral proceedings( ) l)Reports ( ) k)Others ----------

9. Remarks:

Certified that the Proposals are submitted as per rules and procedure as existing rules amended from time to time.

Solicit favourable further orders in this regard.

Thanking you

Yours obiediently

Enclosures:all the above in coloumn8

---

sites.google.com/sites/kimidisrinivas010

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By Regd.Post

From:

To
The Commissioner &
Director of School Education, A.P.
O/o Director of School Education,
Near: Telephone Bhavan,
Saifabad.
Hyderabad.

L. Dis No._____/20 Dated: _____

Respected Sir/Madam /,

Sub: Medical Attendance-Submission of Medical Reimbursement Proposals of Smt. /Sri._____ _____ Assistant /pensioner /FP of _____ School, Regarding.

Ref: 1) GO Ms. No 105 M&H Dt. 09-04-2007
2) GO Ms.No 40 Edn Dt 07-05-2002
3) Proposals Received from the Concerned Teacher.

The Proposals for Medical Reimbursement Received from the Incumbent are here with submitted as detailed below for taking further necessary action in this regard.

1. Name of the Teacher & Post and Employee Code :-==========

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APPENDIX --- II

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

1. Name and Designation (In Block Letters) :
2. Office in which employed :
3. Pay of the Govt.Servant as defined in F.Rs. And other emoluments which should be Shown separately :
4. Place of duty :
5. Full residential address with D.No. and Name of the Mohalla :
6. Name of the patient him/her relationship to The Govt.servant(In case of children Stage age) :
7. Place at which patient fall 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 essentially certificate Should be atac hed each in duplicate signed By treatment doctor. :
10. Total amount claimed :
11. List of enclosures :

I. Check List	[ ]	ii. Essential Certificate	[ ]
iii. emergency Certificate	[ ]	iv. Discharge summary	[ ]
v. Consolidation Bills	[ ]	vi. Medical Cash bill	[ ]
vii. Operation Notes	[ ]	viii. Dependence certificate	[ ]
ix. Non-Drawal Certificate	[ ]		

DECLARATION

I hereby declare that the statement in this application are 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 Govt.Servant Medical attendance rules and wholly dependent upon me.

Signature of Forwarding Authority

signature of govt servant

PRTU GNT

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Signature of Forwarding

Authority signature of govt servant

PRTU GNT

NON-DRAWL CERTIFICATE

Sri. _____ (Designation) _____

Of _____ School has not claimed the amount of

Rs. _____ for the period of treatment i.e. from _____

To _____ previously and this is the _____

Spell for the _____ disease and entered in the Medical Reimbursement

Register.

Signature Government Servant. Signature of the Forwarding Authorities

DEPENDENT CERTIFICATE

Sri/Smt. _____ Son/Daughter/Spouse/Parents of

Sri._____ Designation _____

Of _____ school has not an Employee/Pensioner & fully dependent on me

And he/She has n other source of income and completely dependent on me.

Signature of Applicant. Signature of the Forwarding Authorities.

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SPECIMEN CHECK LIST

(Vide RCNo.8878/D3-4/2009, Dt. 02-09-2009 of C &DSE AP, Hyderabad)

1	Name and Address of the employee Employee Code		
2	If Retired a) Date/ Year of Retirement b) Designation c) P.P.O.No.		
3	Communication of the Applicant Address For all purposes with cell No.		
4	Name and Address of the Hospital a) Whether it is Private Hospital (or) Recognized Hospital b) Whether referral Letter produced (or) Recognized orders to be enclosed along with the proposals)		
5	Whether the Medical Reimbursement Proposal sent with in 6 Months from the Date of discharge.		
6	Whether the following are enclosed 1) Appendix-II duly attested by the Head of the office/DDO 2) Emergency Certificate 3) Discharge Summary 4) 5) Non drawl certificate 6) Essentiality certificate, attested by the authorized doctor, who undertakes treatment 7) If the Patient is dependent on the Govt.Employee-Un employee certificate and dependency certificate are to be enclosed with the Medical Reimbursement Proposals. 8) In case of the dependents of deceased Govt. Employee/Retired employee whether legal heir certificate is enclosed (or) not. 9) Whether the medical reimbursement proposal is prepared and submitted with reference to G.O. Ms.No.74 H.M. & FW (K1) Dept.dt.15-03-2005 and G.O.Ms.No. 60HM &FW(K1) Dept. dt 15-10-2003 and also G.O. Ms. No. 105 HM & FW(K1) Dept. dt.09-04-2007 and also G.O. Ms.No180 dt. 11-05-2006		
9	Whether the medical reimbursement claim is processed through the drawing officer and received with in the stipulated time.		
10.	And whether the availment of No. of installments recorded (or) not.		
11	Whether an entry is made in the Service Register (or) not for previous claim		

Signature of Forwarding Authorities.

02-09-2009 of C &DSE AP, Hyderabad) 1 Name and Address of the employee

Employee Code 2 If Retired

a) Date/ Year of Retirement b) Designation c) P.P.O.No.

3 Communication of the Applicant Address

For all purposes with cell No. 4 Name and Address of the Hospital

a) Whether it is Private Hospital (or)

Recognized Hospital

b) Whether referral Letter produced (or) Recognized orders to be enclosed along with the proposals) 5 Whether the Medical Reimbursement

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NON-DRAWAL DECLARATION OF THE APPLICANT

I, Mr./Mrs. _____
(Surname & Name)

Retd. _____
(Designation, School Name, Village, Mandal and District)

_____

receiving the Family/Service pension vide P.P.O. No. _____ and

_____
(SB A/c. No., Bank Name, Branch Name and Mandal/Town/City)

_____

is hereby declare that, I am not claimed previously the amount of Rs. _____ (Rupees _____ only) from the department towards the reimbursement of medical expenditure incurred for self treatment (or) the treatment of my spouse/child/parent _____ for recovery
(Name and Age)

of _____
(Disease)

during the period from _____ to _____ at _____ and not received any
(Hospital Name & Address)

part of the above amount so far.

Further, I declare that, it is a First/Second/third ( ) claim during my entire service and after retirement period.

Station:
Date:

Signature:
Full Name:
Residential Address:

Contact Phone No.

Certified that the amount of Rs. _____ (Rupees _____ only) furnished by the applicant in the above declaration has not been drawn from STO/DTO/PAO _____ (Dist.) _____ and disbursed to him/her as per available records of this office and also with reference to the records of the Treasury Office.

Station:
Date:

Signature of the DDO with Seal.

DDO Code at Treasury Office:

Treasury Office Code:

Postal Address of the Office/School: -

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I, Mr./Mrs. _____
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Treasury Office Code:

Postal Address of the Office/School: -

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(Designation School Name, Vmage. Mandal and District)

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Date:

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(Surname a Name)

(Designation, School Name, Village, Manda! and Dlstrlci)

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(SB Alc. No., Bank Name. Branch Name and MandallTownlClty)

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