

KENDRIYA VIDYALAYA

Form of application for claiming refund of medical expenses incurred in connection with treatment of
Central Government Servants and their families

1. Name and Designation of Govt. Servant :
2. i) Whether married or unmarried :
- ii) If married, the place where spouse is employed :
3. Office in which employed :
4. Pay of the Govt. Servant :
5. Place of duty :
6. Actual residential address :
7. Name of patient and relationship :
8. Place at which patient fell ill :
9. Details of amount claimed-
 - i) Fees for consultation indicating-
 - a) The name & designation of Medical officer consulted and the hospital to which attached :
 - b) The number and dates of consultation and the fee Paid for each consultation :
 - c) The number and dates of injection and the Fee Paid for each injection :
 - d) Whether consultations and/or injections were had at the hospital, at the consulting room of MO or 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 undertaken and :
 - b) whether the tests were undertaken on the advice of the AMA :
9. Cost of medicines purchased from the market :
10. Hospital charges : Rs._____
11. Total amount claimed : Rs._____
12. List of encls. :
Essentially Certificate A, Prescription (), Hospital charges (), Cash Memoes ()

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

Dated _____

SIGNATURE OF APPLICANT

Passed for payment of Rs.....(Rupees.....)

PRINCIPAL

ESSENTIALITY CERTIFICATE

Certificate granted to Sri/Smt/Km.....
wife/daughter/son/parent of

CERTIFICATE 'A'

I, Dr. hereby certify:-
a) That I charged and received Rs.____ for consultation on _____ at OPD during hospital hours.
b) that I charged and received Rs. NIL for administering injections.
c) that the injections administered were not for immunizing or prophylactic purposes.
d) that the patient has been under treatment at and that the under mentioned medicines prescribed by me in the connection were essential for the recovery of serious deterioration in the condition of the patient. The medicines are not supplied to patient from the polyclinic.

CM No. & date	Name of medicines	Price	Reb ate	Total Bill	CM No. & date	Name of medicines	Price	R e b a t e	Total Bill
GRAND TOTAL									

- e) that the patient is suffering from and is under my treatment from to
- f) that the patient was not given pre-natal or post- natal treatment.
- g) that the X-Ray, Laboratory test etc. for which an expenditure for Rs..... was incurred was necessary & were undertaken on my advice.
- h) that referred the patient to Dr..... for specialist consultation.
- i) that the patient did not require hospitalization.
- j) certified that ointment prescribed was not available and the patient was advised to purchase from the market.

Dated

Signature of Authorized Medical Attendant