FORM OF APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES OF GOVERNMENT SERVANTS AND THEIR FAMILIES

1. Name and designation of Government Servant (in block letters) :

2. Pay and Scale of Pay :

3. Office/Dept. in which employed :

4. Place of duty :

5. Residential address :

6. i) Name of patient and relationship of the Government servant to the patient. :

ii) If the patient is spouse of the employee State whether he/she is employed with details. :

iii) If employed whether the declaration of non-receipt of the claim in any form is attached. :

7. Place at which the patient fell ill :

HOSPITAL TREATMENT

8. Whether hospitalized or not :

9. If hospitalized whether in Govt. Hospital or Private (Notified) Hospital and the name of Hospital. :

10. If hospitalized outside the State.

i) Whether the patient was on duty :

ii) Name of Institution :

11. If on special treatment outside the State :

i) Name of Institution :

ii) Whether certificate of Director of Health Services as contemplated in Rule 7 (a) is attached. :

iii) Whether certificate of Director of Health Services as contemplated in Rule 7 (a) is attached. :

12. Last date of treatment :

CHARGES

13. Details of amount claimed (List of medicines, cash memos and essentially certificate should be attached). :

i) Treatment in Government Hospital medicines :

ii) Treatment in Private Institutions :
Bills to be certified indicating emergency of the case :

1. Charges for Medicine :
2. Charges for Treatment :
3. Charges Accommodation :
4. Charges for Lab. Services, etc. :
5. Charges for Diet :

14. Total amount claimed (in figures and words) :

15. List of enclosures

1. Essentially Certificate :
2. List of Cash Bills :
3. Certificate of Medical Officers :
4. Certificate and Declaration :

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANTS

I hereby declare that the statements given above are true to the best of my knowledge and belief and the person for whom medical expenditure has been incurred is wholly dependent on me.

Place:

Date:

Signature of Government Servant

FORM OF ESSENTIALITY CERTIFICATE

I certify that Shri/Smt …… …… …… …
employed in the …… …… …… ……..
…… …… has been under treatment at this hospital/dispensary or at his /her residence for the period from …… to …….. and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterroration in the condition of the patient. They do not include proprietory preparations for which cheaper substance of equal therapeutic value are available, nor preparations which are primary foods, tonics, toilet preparations of disinfectants.

It is certified that the case did not require hospitalization but is one of prolonged nature requiring medicine attendance at out-patient department spreading over a period of more than 10 days.

The patient was/has been suffering from ……..…….. …… (Name of Disease)

Trade/Brand Name of medicines	Chemical/Pharmacological name of medicines	Description	Price Rs. Ps.

Date: ***Name and designation of the Authorised Medical Attendant***

(Office seal) ***Name of Institution***

D E C L A R A T I O N

I…… ……..... (here enter name and office address, in the case of employee) OR ……..…… ……. (here enter name of patient and relationship of the employee to the patient, in the case of family member) of mine have has been under treatment at the …….. Hospital/Dispensary/at my/his/her/residence during the period of treatment from ……. to ……. and I/he/she have/has received the benefit of one system of treatment and not taken advantage of more than one system simultaneously.

Signature :

Place: **Name :**

Date: **Designation :**

Office Address :