FORMS AND CERTIFICATES
APPENDIX II FORM

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 Letter) :
2. Office of the employee :
3. Pay of the Govt. Servant as defined in FRs and other 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 duplicated signed by treatment doctors :
10. Total amount claimed : Rs.
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	[ ]		
x Referral proceedings	[ ]		
xi Reports	[ ]		
xii Pension	[ ]		
xiii Others_____	[ ]		

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT / PENSIONER

I here by declared that the statement in the 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 Forwarding authority and office to which attested

Signature of Govt. Servant / Pensioner

CERTIFICATE – A

(To be completed in the case of patients who are not admitted to hospital for treatment for the following cases only along with ORIGINAL OUT PATIENT (OP) SLIP FROM CONCERNED DOCTOR)
(Cancer follow up cases , Renal failure cases on dialysis ,Cardiac cases on treatment)

1. I Dr. …… hereby certify

a) That 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) ay my consulting room at the residenceof 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 value are available or 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 my active at the ……. (name of the hospital or laboratory .

h) That referred the patient of Dr……for specialist multilation 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 Attendance**

ESSENTIALITY CERTIFICATE

I Certify that Mrs. / Mr. / Miss …… … Wife / Son /Daughter of Mr/Mrs…… employed in the …… has been under my treatment for …….. diseases from ……to …… at ……..Hospital / my consulting room and that the under mentioned medicine prescribed by me in this connection were essential for the recovery / prevention of serious deterioration the condition of the patient . The Medicines are not stocked in the ……Hospital (for supply to patients) and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available or preparations which are primarily foods, toilets of 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……aged 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

NON DRAWAL CERTIFICATE

Certified that the claim of reimbursement of medical expenses incurred by Sri…… retired/ working as …… on his treatment for ……..……..... from ……..to …….. at ……Hospitals ……... amounting to Rs…… (Rupees …… …… Only) was neither preferred nor drawn previously.

Signature and designation

DECLARATION CERTIFICATE

I ……. (Full name & Designation here by declare that my father / Mother Sri / Smt. ……has no property or income of his / her own and that he / she is wholly dependent upon me

Station: …….

Date: Signature & Designation

CHECKLIST

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 within 6 Months from the Date of discharge.	
6	Whether the following are enclosed	
	1) Appendix-II duly attested by the Head of the office	
	2) Emergency Certificate	
	3) Discharge Summary	
	4) Non drawl certificate	
	5) Essentiality certificate, attested by the authorized doctor, who undertakes treatment	
	6) If the Patient is dependent on the Govt.Employee-An employee certificate and dependency certificate are to be enclosed with the Medical Reimbursement Proposals.	
	7) In case of the dependents of deceased Govt. Employee/Retired employee whether legal heir certificate is enclosed (or) not.	
	8) 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	
7	Whether the medical reimbursement claim is processed through the drawing officer and received with in the stipulated time.	
8.	And whether the availment of No. of installments recorded (or) not.	
9	Whether an entry is made in the Service Register (or) not for previous claim	

SIGNATURE OF FORWARDING AUTHORITY

APPLICATION FOR MEDICAL REIMBURSEMENT

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

2. Name of Office and Place of work :----------

3. Name of the Patient and his relationship with Employee :----------

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

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	[ ]		
x Referral proceedings	[ ]		
xi Reports	[ ]		
xii Pension	[ ]		
xiii Others_____	[ ]		

9. Remarks:

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

Thanking you

Yours faithfully,