**APPENDIX-VIII**

**Med – 97**

**FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE OR TREATMENT OF CENTRAL GOVERNMENT SERVANTS OR THEIR FAMILIES FOR**

**TREATMENT IN A HOSPITAL**

1. Name & Designation of the : ………………………………………

Government servant (in block letter).

a) Whether married or unmarried. : ………………………………………

b) If married, the place where wife/ : …………………………………………

 husband is employed.

2. Office in which employed. : ………………………………………

3. Pay of the Govt. Servant as defined in : ..………………………………………

 the fundamental Rules and any other

 emoluments which should be shown

 separately.

4. Place of duty. : ………………………………………

5. Actual residential Address. : ………………………………………

6. Name of the patient and his/her : .………………………………………

 relationship to the Govt. Servant.

7. Place at which the patient fell ill. : ………………………………………

8. Details of the amounts claimed. : ………………………………………

I. MEDICAL ATTENDANCE : .………………………………………

II. HOSPITAL TREATMENT -

 Name of the Hospital. : .………………………………………

 Charge for hospital treatment Indicating

 separately the charge for

 i) Accommodation (State whether it : .………………………………………

 was according to the status or pay

 of the Govt. Servant and in cases

 where the accommodation is higher

 than status of the Govt. Servant, a

 certificate should be attached to the

 effect that the accommodation to which

 he was entitled was not available).

 ii) Diet : .………………………………………

 iii) Surgical operation or medical

 treatment or confinement. : .………………………………………

 iv) Pathological, bacteriological,

 radiological or other similar : .………………………………………

 tests indication.

 a) the name or the hospital or : .………………………………………

1. whether undertaken on the advice : .………………………………………

 of the medical officer in charge of

 the case at the hospital. If so, a

 certificate to that effect should

 be attached.

 v) Medicines. : .………………………………………

 vi) Special medicines (Cash memos and : .………………………………………

 the essentiality certificates should be

 attached).

 vii) Ordinary nursing. : .………………………………………

*..2/-*

-2-

 viii) Special nursing, i.e. nursing, specially : .………………………………………

 engaged for the patient, State whether .………………………………………

 they are employed on the advice of the

 medical officer in-charge of the case at

 the hospital or at the request of the Govt.

 Servant or patient. In the former case of

 a certificate from the medical officer

 in-charge of the case and countersigned

 by the Medical Superintendent of the

 hospital should be attached.

 ix) Ambulance charges (State the journey : .………………………………………

 to and fro-undertaken).

 x) Any other charges e.g. charges for : .………………………………………

 electric light, fan, heater,

 air conditioning etc. State also whether.

III. CONSULTATION WITH SPECIALIST - : .………………………………………

 Fees paid to a Specialist or a Medical

 Officer than the authorised medical

 attendant, indicating.

 a) Name and designation of the Specialist : .………………………………………

 or Medical Officer consulted and the

 hospital to which attached.

 b) Number and dates of consultations : .………………………………………

 and fees charge for each consultation.

 c) Whether consultation was had at the : .………………………………………

 hospital, at the consulting room of the

 Specialist or Medical Officer, or at the

 Residences the patient and.

 d) Whether the Specialist or Medical

 Officer was consulted on the advice

 of the authorized, medical attendant

 and the prior approval of the Chief

 Administrative Medical Officer of

 the State was obtained, If, so a

 certificate to that effect should be

 attached.

9. Total amount claimed. : .………………………………………

10. Less advance taken on. : .………………………………………

11. Net amount claimed. : .………………………………………

12. List of enclosures : .………………………………………

**DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT**

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

Date ………………... Signature of the Government

 Servant and Office to which attached.

**APPENDIX – XIV**

ESSENTIALITY CERTIFICATE

**CERTIFICATE – ‘A’**

*(To be completed in the case of patients who are not*

 *admitted to Hospital for treatment)*

Certificate granted to Mrs./Mr./Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ wife/son/daughter of Mr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ employed in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby certify:-

1. that I charged and received Rs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consultation on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dates to be given) at my consulting room/at the residence of the patient;
2. that I charged and received Rs.\_\_\_\_\_\_\_\_\_\_\_\_ for administering \_\_\_\_\_\_\_\_\_\_\_\_ intravenous/intra-muscular/subcutaneous injections on \_\_\_\_\_\_\_\_\_\_\_\_\_\_(dates to be given) at \_\_\_\_\_\_\_\_\_\_\_\_\_\_ my consulting room/the residence of the patient;
3. that the injections administered were not/were for immunizing or prophylactic purposes;
4. that the patient has been under treatment at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hospital/my 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparation which are primarily foods, toilets or disinfectants.

 **Name of medicines Price**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. that the patient is/was suffering from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and is/was under my treatment from \_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_;
2. that the patient is/was not given pre-natal or post-natal treatment;
3. that the X-ray, laboratory test, etc., for which an expenditure of Rs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ was incurred was necessary and were undertaken on my advice at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of the hospital or laboratory);
4. that I referred the patient to Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for Specialist consultation and that the necessary approval of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of the Chief Administrative Officer of the State) as required under the rules was obtained;
5. that the patient did not required/require hospitalization.

Signature of AMA/Designation of

Dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the Medical Officer and hospital/

dispensary to which attached

***N.B. -*** Certificates not applicable should be truck off. Certificate (e) is compulsory and must

be filled in by the Medical Officer in all cases.

**APPENDIX – XIV**

**ESSENTIALITY CERTIFICATES**

**CERTIFICATE ‘B’**

*(To be completed in the case of patients who are admitted to hospital for treatment)*

 Certificate granted to ………………...................................................................

Mrs/Mr/Miss…………………………………………………………………………………...

Wife/son/daughter of…………………… Mr………………………………………………….

employed in the………………………………………………………………………………...

**PART – A**

I Dr……………………………………….. hereby certify:-

(a) That the patient was admitted to hospital on the advice of …….…………………………..

 name of the medical office) on my advice:

(b) That the patient been under treatment at ……………………………... and that the under mentioned medicals prescribed by me in this connection were essential for the recovery/prevent of serious deterioration in the condition of the patient. The medicines are not stocked in the ……………………………………….. (name of the Hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available or preparations which are primarily food, toilets or disinfectants.

**Name of Medicines** **Price**

1. ………………………………………….. ……………………

2. ………………………………………….. ……………………

3. ………………………………………….. ……………………

4. ………………………………………….. ……………………

(c) That the injections administered were/were not for immunizing or prophylactic purposes.

(d) That the patient is/was suffering from………………………………………….. and is/was under treatment from ………………….. to ……………………..

(e) That the X-ray, laboratory tests etc. for which an expenditure of Rs………………/ was incurred were necessary and were undertaken on my advice at……………………………. (name of Hospital or laboratory).

(f) That I called on Dr…………………………………………………….. for specialist consultation and that the necessary approval of the …………………………….…… (Name of the Chief Administrative Medical Officer of the State) as required under the rules, was obtained.

 Signature and Designation of the Medical Officer

 in charge of the case at the Hospital

**PART – B**

 I certified that the patient has been under treatment the ……………….……. Hospital and that service of the special nurses for which an expenditure of Rs. ……………….. /- was incurred, vide bills and receipts attached, were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Signature and Designation of the Medical Officer

 in charge of the case at the Hospital

**COUNTERSIGNED**

Medical Superintendent ………………………………………………… Hospital.

 I certify that the patient has been under treatment at the …………….………….….

Hospital and that the facilities provided were the minimum which were essential for the patient’s treatment.

Place: …………………….. Medical Superintendent

..…………………………….. Hospital