MEDICAL REIMBURSEMENT CLAIM FOR INPATIENT TREATMENT

Note: Separate application form should be submitted for each patient

1. Name & Designation of the employee (in block letters) : _____
   (i) Whether married or unmarried : _____
   (ii) If married, the place where wife/husband is employed : _____
2. Office in which employed : _____
3. Pay of the employee as defined in the F.R. and 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 employee : _____
   (N.B. In case of children state age also)
7. Place at which the patient fell ill : _____
8. Name of the Hospital : _____
9. Charges for hospital treatment, indicating separately the charges for :-

a) Accommodation (State whether it was according to the status or pay of the employee and in case where the accommodation is higher than the status of the employee, a certificate should be attached to the effect that the accommodation to which he was entitled was not available). : _____

b) Diet : _____

c) Surgical operation/Medical treatment or confinement : _____

d) Pathological, bacteriological, radiological or other similar tests including :-

(i) The name of hospital or lab at which undertaken : _____

(ii) Whether undertaken on the advice of the Medical Officer in-charge of the case at the hospital. If so, a certificate to the effect should be attached : _____

e) Medicines including special medicines (Cash memos and the Essentiality Certificates should be attached) : _____

f) Ordinary nursing : _____

g) Special nursing, i.e., nurses, 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 Government servant or patient. In the former case, a certificate from the Medical Officer in-charge of the case and countersigned by the Medical Superintendent of the hospital should be attached : _____

h) Ambulance Charges (State the journey _____to and fro _____ undertaken : _____

i) Any other charges, e.g., Electric lighting, fans, heater, air conditioning etc. State also whether the facilities referred to are a part of the facilities normally provided to all patients and no choice was left to the patient : _____

Contd...2

NOTE 1. – If the treatment was received by the employee at his residence under Rule 7 of the CS (MA) Rules, 1944, give particulars of such treatment and attach a certificate from the Authorized Medical Attendant as required by these rules.

NOTE 2. – Deleted vide G.I., M.H., O.M. No. S.14025/35/2007-MS, dated the 1st/17th October, 2007.

10.	Total amount claimed		: Rs. _____
11.	Less advance taken on	_____	: Rs._____
12.	Net amount claimed		: Rs _____
13.	List of enclosures		: _____

DECLARATION TO BE SIGNED BY THE EMPLOYEE

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 employee
and Office to which attached

Contd...3

CERTIFICATE "B"

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..... on my advice

(b) That the patient has been under treatment at.....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 the hospital) for supply to private patient and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants.

Sl.No.	Name of Medicines	Prices
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

(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.....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

Contd...4

PART - B

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

Medical Superintendent
…….…….. Hospital

Place……

Date……

NOTE : Certificates not applicable should be struck off. Certificate (B) is compulsory and must be filled in by the Medical Officer in all cases.

** The 'minimum facilities certificate' may be signed either by the Medical Superintendent of the hospital concerned or another Gazetted Medical Officer who has been authorized in this behalf by the Medical Superintendent.*

[G.I., M.H., O.M. No. F. 2–35/52-LSG (H.I.), dated the 19th September, 1958]