ASSAM UNIVERSITY SILCHAR

असम विश्वविद्यालय सिलचर

CERTIFICATE 'A'

Form of Application for Medical Claims

(To be completed in the case of all patients both admitted/not admitted to hospital for treatment)

For of application for claiming refund of medical expenses incurred in connection with medical attendance and/or treatment of Central Government servants and their facilities for medical attendance/treatment taken both from Authorized Medical Attendant and a Hospital.

1. Name and Designation of the Employee(in block letters)**:**

(i) Whether married or unmarried **:**

(ii) If married, place where wife/husband is employed **:**

2. Office in which employed **:**

3. Pay of the employee as defined in the Fundamental Rules and any other emoluments which should be shown separately **:**

4. Place of duty **:**

5. Actual residential address **:**

6. Nam of the patient and his/her relationship with the Government servant **:**

7. Whether the person in respect of whom the claim is made is /are legally a dependent upon the Govt. servant **:**

8. Place at which patient fell ill **:**

9. What type of leave was sanctioned for the purpose? State the duration of the leave sanctioned **:**
(in case of the employee himself/herself if treatment is done outside the headquarters, copy of leave order to be enclosed)

10. Details of the amount claimed

i) Fees for consultation **:**

ii) Charges for pathological, bacteriological, radiological or other similar tests undertaken during diagnosis**:**

iii) Cost of medicines purchased from the market (cash memos and essentiality certificates should be attached):

Sl.No.	Name of Medicines	Quantity	Price (in Rs.)	Amount (in Rs.)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Note 1.

If the treatment was received by the Government servant at his residence under Rule 7 of the SC (MA) Rules, 1944, give particular of each treatment and attach a certificate from the authorized medical attendant as required by these rule

11. Consultation with specialist :

12. Total amount claimed : Rs.

13. Bank Account No. :

14. Contact No.

:

<u>DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT</u>

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 the office to which attached

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I certify that the patient has been under the treatment of Dr. ………………………………………………. and that after scrutiny the admissible medicines/Tests are as follows:

Sl. No.	Name of Medicines/Clinical	Quantity	Price	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Date:

Medical Officer
Health Centre, Assam University

For Office

use only Total admissible amount: __________________________

Signature

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CERTIFICATE 'B'

ESSENTIALITY CERTIFICATES

(To be completed in the case of patients who are not admitted to hospital for treatment)

This is to Certify that Mrs./Mr./Ms………………………………………………………………………….....wife/son/daughter

of………………………………………………………has been suffering from ………………………………………..and the

medicines/investigation prescribed for ………………………....days/months/year are essential for recovery. The details of the

medicines and investigations are referred in the prescription.

Date:

Signature of AMA/Designation of the Medical

Officer and hospital/dispensary to which attached

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ESSENTIALITY CERTIFICATES

CERTIFICATE 'C'

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

PART-A

1. Dr…………………………………………………….……hereby certify that-

   a) That the patient was admitted to hospital on the advice of …………………………………………………….. (name of the Medical Officer)/ on my advice;

   b) 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 the Hospital) for apply 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 the medicine	Quantity	Price (in Rs.)	Amount (in Rs.)

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

   d) that the patient is/ was suffering from………………………………………………… and is/was under my treatment from…………………………..to………………………

e) 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);

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.

Date:

Signature of AMA/Designation of the Medical Officer and hospital/dispensary to which attached

PART-B

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

Date :

Medical superintendant

.... hospital

Note : Certificates not applicable should be struck off. Certificate (d) is compulsory and must be filled by the medical officer.