CERTIFICATE 'A'

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

FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE OR TREATMENT OF THE EMPLOYEES OF NSU AND THEIR FAMILIES.

1. Name & designation of the Employee (**In Block Letters**) :
2. Office/Department in which employed :
3. Pay of the employee as detailed in FR 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 (NB in case of the children state age) :
7. Place in which the patient fell ill :
8. Nature of the illness and its duration :
9. Details of the amount claimed :

a) Fees for consultation indicating the name & designation of the Medical Officer consulted the Hospital/Dispensary to which attached The number & date of consultation and the fees paid for each consultation. Whether consultation was at the Hospital, at consulting room of the Medical Officer or at residence of the patient :

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

c) Cost of medicines purchased from the market :

Sl.No.	Bill No./Voucher No.	Date	Amount (in Rs.)

10. Total Amount claimed :
11. Bank Details

Bank Name	Branch Name	Account No.	IFS Code	PFMS No.

DECLARATION TO BE SIGNED BY THE EMPLOYEE

Enclosure: (Please tick the appropriate option)		
1.	Original Prescription or Certificate "B"	☐
2.	Cash memo/Bills in original	☐
3.	Test reports (Photo Copy)	☐
4.	Self-Certification of all the bills/cash memos/vouchers	☐
5.	Certificate "C" for hospitalization cases along with discharge certificate in original	☐
6.	Clain submitted against each Prescription / Visit.	☐
7.	Physiotherapy Treatment bill with Prescription.	☐
8.	Mention lens/glass bill amount in case of spectacle bill	☐
9.	Mention page numbers in all pages of the claim	☐
10.	Bill submitted within six months of first consultancy	☐

I do hereby declare that the statements in the application are true to the best of my knowledge and belief and that the person from whom medicine expenses were incurred by me for treatment of self/dependent.

_____

Place: Signature of the employee

Date: Department to which attached

For Office use only

Total admissible amount: Rs._____ Rupees_____only.

_____

Signature of D.D.O

Acknowledgement

Received medical claim from _____ for Rs. _____

Vide docked no._____ dated _____.

_____

Signature of Recipient

CERTIFICATE- 'B'

(To be completed in case of the patient who are not admitted in 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/years are essential for recovery. The details of medicines and investigations are refereed in the prescription.

Date:

_____
Signature & Designation of the
Medical Officer &
The Hospital/Dispensary to which attached.

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 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.)
			Total	

c) that the infections 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 necessary and were undertaken on my advice at _____ (Name of the hospital of 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 & Designation of the
Medical Officer &
The 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

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 Superintendent
_____hospital

Note: Certificates not applicable should be struck off.