FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE &/OR TREATMENT OF CENTRAL GOVT. SERVANT & THEIR FAMILIES

N.B. Separate Form should be used for each patient

Sr.	Particulars	
1	Name & Designation of the Govt. Servant (in BLOCK LETTERS)	
2	Office in which employed	IIPS, Deonar, MUMBAI-400 088.
3	Pay of the Govt. Servant as defined in the fundamental Rules & other emoluments which should be shown separately.	
4	Place of Duty	IIPS, Deonar, MUMBAI-400 088.
5	Actual Residential Address	
6	Name of the Patient & his/her relationship to the Govt. Servant (N.B.) in case of children, state the age also.	
7	Place at which patient fell ill	
8	Details of the amount claimed i) Fee for consultation a) The name & designation of Medical Officer consulted & the Hospital/Dispensary to which attached b) The number and date of consultation and other fee paid for each consultation c) The number and date of injections & the fee paid for each injection. d) Whether consultation &/OR injections were had at the hospital, at the consulting room of the medical officer or at the residence of the patient.	
	ii) Charge for pathological, bacteriological, radiological or other similar tests undertaken during diagnosis indicating a) The name of the hospital/laboratory where the tests were undertaken, & b) Whether the tests were undertaken on the advice of the authorized medical attendant, if so, certificate to that effect should be attached.	--Investigations:
	iii) Cost of medicines purchased from the market (List of medicines, cash memo No. and the essentiality certificate should be attached).	Rs.
9	Total amount claimed	Rs.
10	List of enclosures:	Dr. Prescription Note Cash Memo

DECLARATION TO BE SIGNED BY THE GOVT. SERVANT

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

Date: / /201 Sign. of the Govt. Servant.

Certified to Mr./Mrs./Miss _____ father/mother/wife/son/ daughter of Mr./Mrs. _____employed in International Institute for Population Sciences, Deonar, MUMBAI – 400 088.

CERTIFICATE `A'

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

I, Dr. U.M Shenoy/ Dr. R.V. Ambekar hereby certify:

(a) That I charges and received Rs._____ for _____consultation on _____ (dates to be given) at my consulting room/residence of the patient.
(b) That I charge and received Rs. _____ for administering _____ intra-venous/ intra-muscular/subcutaneous injections on _____ (dates to be given) at _____ my consulting room/the residence of the patient.
(c) That the injection administered were not/were for immunizing or prophylactic purposes.
(d) That the patient has been under treatment at IIPS/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 Govt./ Municipal Hospital for supply to private patients and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available nor preparation of which are primarily foods, toilets or disinfectants.

MEDICINES (Please write in CAPITAL letter)	AMOUNT	MEDICINES (Please write in CAPITAL letter)	AMOUNT
		Total	

(e) That the patient is/was suffering from _____ and is/was under my treatment from _____ to _____
(f) That the patient is/was not given prenatal or postnatal treatment.
(g) That the x-ray laboratory tests etc., which an expenditure of Rs. _____ was incurred was necessary and were undertaken on my advice at _____ (Name of the hospital & Laboratory).
(h) That I referred the patient to Dr._____ for specialists consultation and that the
Necessary approval of the _____ (Name of the Chief Admin. Medical Office of the State) as required under the rule was obtained.

(i) That the patient did not require/required hospitalization.

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

Date:

N.B. Certificate not applicable should be struck off certificate 'A' is compulsory and must be filled in by the Medical officer in all cases.