FORM OF APPLICATION FOR CLAIMNG RE-IMBURSEMENT OF MEDICAL EXPENSES OF BOARD STAFF AND THEIR FAMILIES

1. Name and designation of Board Staff (in block letters) -

2. Pay and Scale of pay -

3. Office in which employed -

4. Place of duty -

5. Residential Address -

6. (I) Name of Patient and relationship of the Board Staff to the Patient -

(ii) If the patient is spouse of the employee, state whether he/she is employed with details -

(iii) If employed, whether the declaration of non-receipt of the claim in any form is attached -

7. Place at which the patient fell ill -

HOSPITAL TREATMENT

8. Whether hospitalised or not -

9. If hospitalised whether in Government Hospital or private(Notified) Hospital and the name of Hospital -

10. If hospitalised outside the State

(1) Whether the patient was on duty -

(ii)Name of institution -

11. If on special treatment out side the state

(1) Name of institution -

(ii) Whether certificate of Director of Health services as contemplated in rule 7 (a) is attached -

(iii) Whether prior sanction of Director of health services has been obtained -

12. Last date of treatment -

CHARGES

13.Details of amount claimed (List medicines, Cash memos and essentiality certificate should be attached)-

(1) Treatment in Government hospital Medicines
(ii) Treatment in private institutions (bills to be certified indicating emergency of the case)

1.Charges of medicine	-
2.Charges of Treatment	-
3.Charges of Accommodation	-
4.Charges of Lab Service	-
5.Charges of Diet	-

14.Total amount claimed (in figures and in words)	-
15.List if enclosures	-
1.Essentiality certificate	-
2.List of cash bills	-
3.Certificate of Medical officer	-
4.Certificate and declaration	-

DECLARATION TO BE SIGNED BY THE BOARD STAFF

I hereby declare that the statements given above are true to the best of my knowledge and believe and the person for whom medical expenditure has been incurred is wholly dependent on me.

Place

Signature of the Applicant

Date

ESSENTIALITY CERTIFICATE

I certify that Sri./Smt. …… …… …… …… … …… ……employed in the ……department has been under treatment at this Hospital/ Dispensary or at his/ her residence for the period from ……..to…….and that the undermentioned medicines prescribed by me in the connections were essential for the recovery /prevention of serious deterioration's in the condition of the patient. They do not include proprietary preparations, for which cheaper substance of equal therapeutic value are available. Nor preparations which are primary foods, tonics, toilet proportions or disinfectants.

It is certified that the case did not require hospitalisation but is one of prolonged nature requiring medical attendance at the out patient department spreading over a period of more than 10 days.

The patient was/has been suffering from…….(Name of disease)

Trade/Brand Name of Medicines	Chemical/Pharmacological Name of Medicine	Description	Price

Name & Designation of the
Authorised Medical Attendant.
Name of Institution.

DECLARATION

I…….employed in the …… …… …… …… …… …… ……Department ……..relationship…… ……mine/have/ has been under treatment at the hospital/Dispensary at my/ his residence during the period the benefit of the system of treatment from ……to…….and I/her/she/he have has received the benefit of one system of treatment and not taken advantage of more than one system of simultaneously.

Signature :
Name :
Designation :
Department :