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

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Sr.	Particulars			
1	Name & Designation of the Govt. Servant			
	(in BLOCK LETTERS)			
2	Office in which employed			
3	Pay of the Govt. Servant as defined in the fundamental Rules &			
	other emoluments which should be shown separately.			
4	Place of Duty			
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.			
	<ul> <li>d) Whether consultation &amp;/OR injections were had at the hospital, at the consulting room of the medical officer</li> </ul>			
	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.			
	iii) Cost of medicines purchased from the market			
	(List of medicines, cash memo No. and the			
	essentiality certificate should be attached).			
9	Total amount claimed			
10	List of enclosures:			

## **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.

Certified to Mr./Mrs./Miss Self	<u> </u>	father/mother/wife/son/ daug	ghter of Mr./Mrs.			
employed in International Institute for P	opulation Scie	nces, Deonar, MUMBAI – 400 088.				
	CERTI	FICATE `A'				
(To be completed in case	e of patient who	o are not admitted to hospital for treatmer	nt)			
I, Dr. Shenoy hereby certify:						
•		·				
(dates to be given) at my cons	a) That I charges and received Rs forconsultation 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./					
		nts and do not include proprietary prepa				
cheaper substance of equal	cheaper substance of equal therapeutic value are available nor preparation of which are primarily					
foods, toilets or disinfectants.						
MEDICINES		MEDICINES				
(Please write in CAPITAL letter)	AMOUNT	(Please write in CAPITAL letter)	AMOUNT			
	-	and is/was under my	treatment from			
(f) That the patient is/was not give		oostnatal treatment				
(g) That the x-ray laboratory test	<ul><li>(f) That the patient is/was not given prenatal or postnatal treatment.</li><li>(g) That the x-ray laboratory tests etc., which an expenditure of Rs was incurred was</li></ul>					
necessary and were underta	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	DI	ioi specialists cons	ullation and that			
Necessary approval of the						
(Name of the obtained.	Chief Admn. N	Medical Office of the State) as required ur	nder the rule was			
(i) That the patient did not require/	required hospi	talization.				
		Signature of AMA/Designation of the Officer & Hospital/Dispensary to was				
Date:		2 2. Troophan Diopolibary to W				

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.