Appendix 'C'

FORM OF APPLICATION FOR MEDICAL CLAIMS
(चिकित्सा दावों के लिए आवेदन पत्र)

To
(सेवा में),
The Accounts Officer (Reimbursement)
लेखा अधिकारी (प्रतिपूर्ति),
Accounts Section
(लेखा विभाग),
All India Institute of Medical Sciences, Rajkot
अखिल भारतीय आयुर्विज्ञान संस्थान, राजकोट

Kindly arrange to reimburse medical bills of ₹ ..... which was prescribed by the ……
The amount may be credited to my bank account.
कृपया.....के द्वारा नियत(Prescribed) राशि ₹ ..... के चिकित्सा बिल प्रतिपूर्ति करने की व्यवस्था करें। (राशि मेरे बैंक खाते में क्रेड़िट की जा सकती है।)

Full Name of Employee (In capital letters) (कर्मचारी का पुरा नाम)	
Employee Code (कर्मचारी कोड़) (Copy of ID Card attached on page no)	
Status (स्थिति)	(Govt. servant /Pensioner /Other) (सरकारी कर्मचारी/सेवानिर्वत्त/अन्य)
Designation (पद)	
Date of Joining (नियुक्ति दिनाँक)	
Department (विभाग)	
Contact No.(सम्पर्क नं.)	
FOC card of Patient (मरीज का FOC card) (Copy attached on page no….)	
Essentiality Certificate (अनिवार्यता प्रमाण पत्र) (Whichever is applicable tick that one or both)(जो भी लागू हो उस पर या दोनों पर निशान लगायें)	Certificate A / Certificate B (प्रमाण–पत्र A/प्रमाण–पत्र B)
Copy of referral by Govt. specialist (सरकारी विशेषज्ञ द्वारा रेफरल की प्रति) (Applicable in case of treatment taken outside AIIMS)(एम्स के बाहर उपचार के मामले में लागू)	YES / NO (हाँ/नहीं) (Page No.....)
Copy of Discharge Summary (डिस्चार्ज समरी की प्रति) (Applicable Only for IPD Patient)(केवल आईपीड़ी रोगी के लिये लागू)	YES / NO(हाँ/नहीं) (Page No.....)

NOTE(ध्यान दें): -

1. Copies of employee ID-card and FOC card of patient is mandatory to attach along with claim reimbursement form.
(दावा प्रतिपूर्ति आवेदन के साथ कर्मचारी आईडी–कार्ड और मरीज के **FOC** कार्ड की प्रतियाँ संलग्न करना अनिवार्य है।)

2. Please mark page number on each page and all Invoice bills should be self-certified
(कृपया प्रत्येक पृष्ठ पर पृष्ठ–संख्या अंकित करें और सभी चालान बिल स्व–प्रमाणित करें।)

3. Time limit for submission of claim(दावा प्रस्तुत करने की समय–सीमा:

a. **Within six months from the date of completion of treatment.**

4. Medical Reimbursement claim form should be printed on both side.

Dated(दिनाँक): ……

Signature of AIIMS Employee
(एम्स कर्मचारी के हस्ताक्षर)

FORM OF APPLICATIONS FOR MEDICAL CLAIMS

(चिकित्सा दावों के लिए आवेदन पत्र)

MED.97

Form of application for claiming refund of medical expenses incurred in connection with medical attendance and/or treatment for Central Government servants and their families - for medical attendance/treatment taken both from the Authorised Medical Attendant and a Hospital

1.	Name and designation of Government servant (in block letters) (सरकारी कर्मचारी का नाम तथा पदनाम्)	:	
	i) Whether married or unmarried (विवाहित या अविवाहित्)	:	
	ii) If married, the place where wife/husband is Employed (यदि विवाहित, स्थान जहाँ पति/पत्नि कार्यरत है)	:	
2.	Office in which employed(कार्यालय जहाँ कार्यरत है)	:	
3.	Pay of the Government servant as defined in the Fundamental Rules, and anyother emoluments which should be shown separately : (वेतर स्तर)	:	
4.	Place of duty (कार्य का स्थान)	:	
5.	Actual residential address (वास्तविक निवास पता)	:	
6.	Name of the patient and his/her relationship to the Government servant. N.B. - In the case of children state age also	:	
7.	Place at which the patient fell ill (स्थान जहाँ मरीज बीमार हुआ)	:	
8.	Details of the amount claimed (दावा की गई राशि का विवरण)	:	
I. Medical Attendance -			
i) Fees for consultation indicating -			
a) The name and designation of the Medical Officer consulted and the hospital ordispensary to which attached		:	
b) The number and dates of consultation and the fee paid for each consultation.		:	
c) The number and dates of injection and the fee paid for each injection.			
d) Whether consultations and/or injections were had at the hospital, at the consultingroom of the medical officer or at the residence of the patient.		:	
		:	
ii) Charges for pathological, bacteriological, radiological, or other similar tests undertaken during diagnosis indicating- a) The name of the hospital or laboratory where undertaken; and b) Whether the tests were undertaken on the advice of the authorized medicalattendant. If so, a certificate to that effect should be attached.		: :	
iii) Cost of medicines purchased from the market (Cash memos and the essentiality certificate should be attached).		:	
II Hospital Treatment.			
Name of the hospital Charges for hospital treatment, indicating separately the charges for -		:	
i) Accommodation (State whether it was according to the status or pay of the		:	
Government servant and in cases where the accommodation is higher than the status			
of the Government servant, a certificate should be attached to the effect that the			
accommodation to which he was entitled was not available)			
ii) Diet		:	
iii) Surgical operation or medical treatment or confinement. iv) Pathological, bacteriological, radiological or other similar tests indicating -		:	
a) The name of the hospital or laboratory at which undertaken, and		:	
b) Whether undertaken on the advice of the : medical officer in charge of the case at			
the hospital. If so, a certificate to that effect should be attached. v) Medicines.		:	
vi) Special medicines (Cash memos and the essentiality certificates should be		:	
attached)			

vii) Ordinary nursing	:	
viii) Special nursing, i.e., nurses, specially engaged for the patient. State whether they	:	
are employed on the advice of the medical officer in charge of the case at the hospital		
or at the request of the Govt. Servant or patient. In the former case a certificate from		
the medical officer in charge of the case and countersigned by the Medical		
Superintendent of the hospital should be attached.		
ix) Ambulance charges (State the journey - to and from- undertaken)	:	:
NOTE 1. - If the treatment was received by the Govt. servant at his residence under Rule 7 of the C.S. (M.A) Rules, 1944 give particulars of such treatment and attached a certificate from the authorized medical attendant as required by these rules. NOTE 2. - If the treatment was received at a hospital other than a Govt. hospital, necessary details and the		
certificate of the authorized medical attendant that the requisite treatment was not available in the nearest Govt. hospital should be furnished.		
III. Consultation with Specialist - Fees paid to a specialist or a Medical Officer other		
than the authorized medical attendant, indicating –		
a) The name and designation of the Specialist or Medical Officer consulted and the		
hospital to which attached. b) Number and dates of consultations and the fees charged for each consultation.	:	
c) wherever consultation was had at the hospital, at the consulting room of the	:	
Specialist or Medical Officer, or at the residence of the patient, and		
d) Whether the Specialist or Medical Officer was consulted on the advice of the		
authorized medical attendant and the prior approval of the Chief Administrative	:	
Medical Officer of the State was obtained. If so, a certificate to that effect should be		
attached.	:	

11.	Total amount claimed (कुल दावा की गई राशि):	:
12.	Less advance taken on	
13.	List of enclosure (संलग्नक की सूची):	

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT
(सरकारी कर्मचारी द्वारा हस्ताक्षर की जाने वाली घोषणा)

I hereby declare that the statement in the application are true to the best of my knowledge andbelief and that the person for whom medical expenses were incurred is wholly dependent upon me.

(मैं एतद्द्वारा घोषणा करता/करती हुँ कि आवेदन पत्र में दिया गया विवरण मरे सर्वोत्तम ज्ञान और विश्वास के अनुसार सत्य है और जिस व्यक्ति के लिए चिकित्सा व्यय किया गया है वह पूर्ण रूप से मुझ पर निर्भर है)

Dated(दिनाँक).....

Signature of the Employee
(कर्मचारी के हस्ताक्षर)

ESSENTIALITY CERTIFICATE

(अनिवार्यता प्रमाण–पत्र)

CERTIFICATE 'A'

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

Certificate granted to Dr/Mrs./Mr./Miss ..... ……Wife/Son/Daughter of

MR/MRS/MISS ... … … … … . …….Employed in the……..….

I, Dr..... hereby certify:-

(a) that I charged and received Rs. ..…… for ……..... consultations on ..... (dates to be given) at my consulting room/ at the residence of the patient;

(b) that I charged and received Rs…….....for administering.....intravenous/ intra-muscular/ subcutaneous injections on..……..(dates to be given) at…… my consulting Room/the residence of the patient;

(c) that the injections administered were not/were for immunising or prophylactic purposes;

(d) that the patient has been under treatment at..... hospital/ my consulting room and that the undermentioned 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 supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily food, toilets or disinfectants.

Name of Medicines	Price
1.	....
2.	....
3.	....
4.	....

(e) that the patient is/was suffering from ....……..……..

and is/was under my treatment from .....…..... to…….. ;

(f) that the patient is/was not given pre-natal or post-natal treatment;

(g) 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);

(h) that I referred the patient to Dr. ...……..…..... for SPECIALIST consultation and that the necessaryapproval of the .....……(Name of the Chief Administrative Officer of the State) as required under the rules was obtained;

(i) that the patient did not require/required hospitalisation.

Date:……..

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

N.B.:-certificates not applicable should be struck off. Certificate (e) is compulsory and must be filled in by the medical officer in all cases.

ESSENTIALITY CERTIFICATE
(अनिवार्यता प्रमाण–पत्र)
CERTIFICATE 'B'

(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 Mr./ Mrs./ Miss ..... employed ....

PART-A

I, Dr.....…….hereby certify :-

(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 .....;;;;;;;;;;;;;;;;;;;;..... and that the undermentioned 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 supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparations which are primarily foods, toilets ordisinfectants.

NAME OF MEDICINES	PRICE
1.	.....
2.	.....
3.	.....
4.	.....
5.	.....

(c) that the injections administered were/were not for immunising of prophylactic purposes;

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

(e) that the X-ray, laboratory test etc. for which an expenditure of ₹ ..... was incurred were necessary and were undertaken on my advice at (name of 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.

Signature and Designation of the Medical
Officer-in-charge of the case at the hospital.

PART B

Certify that the patient has been under treatment at the.....hospital and that the service of the special nurses for which an expenditure of ₹ ..... ……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.

Medical Superintendent Place
……..Hospital

NOTE:- CERTIFICATES NOT APPLICABLE SHOULD BE STRUCK OFF. CERTIFICATE (B) IS COMPULSORY AND MUST BE FILLED IN BY THE MEDICAL OFFICER IN ALL CASES.

Appendix 'D'

CHECKLIST FOR REIMBURSEMENT OF MEDICAL CLAIMS

1. Full Name of AIIMS Employee … (Block Letter)

2. Status … (Govt. servant/Pensioner/Other)

3. The following documents are sub-mitted (Please tick the relevant column)

   (a) Medical 97 Form : Yes / No

   (b) Photocopy of Identity card : Yes / No

   (c) No of Original Bills ……..

   (d) Copy of Discharge Summary : Yes / No

   (e) Copy of referral by specialist : Yes / No

   (f) whether the hospital has given break-up for lab investigation : Yes / No

   (g) Original papers have been lost the following documents are submitted: -

      i. Photocopies of claim papers : Yes / No

      ii. Affidavit on stamp paper : Yes / No

   (h) In case of death of Employee the Following documents are submitted:-

      i. Affidavit on stamp paper by Claimant : Yes / No

      ii. No Objection from other legal heirs on stamp papers : Yes / No

      iii. Copy of death certificate : Yes / No

Dated: …… Signature of AIIMS Employee

Appendix – 'E'

Draft for Affidavit for Duplicate Claim Papers / Bills on Stamp Paper

I, _____ son / wife / daughter of _____and resident of_____ have lost / misplaced the original paper or the same are not traceable. I hereby given an undertaking that I have not received any payment against the original bills / claim papers from any source and that if the original papers are traced, I shall not stake claim against original bills in future and that in the event, I receive any cheque against the original bills in future, I shall return the same to Competent Authority.

Deponent

Verified by Notary Public.

Appendix 'F'

Draft for Affidavit on Stamp Paper for claiming medical reimbursement IN CASE OF DEATH of a EHS beneficiery.

I, _____ husband / wife / son / daughter of late _____ and resident of _____

hereby submit the medical reimbursement claim papers pertaining to treatment of my husband / wife / father / mother Late Shri / Smt. _____ who has expired on _____ (copy of Death Certificate is enclosed).

Late Shri / Smt. _____ has left behind the following other legal heirs, none of whom have any objection if the entire reimbursable amount is paid to me.

No Objection Certificate signed by other legal heirs on Stamp Paper is enclosed.

Deponent

Attested by Notary Public.

Appendix 'G'

Draft for **"NO OBJECTION CERTIFICATE"** on Stamp Paper.

We,

(i) _____ son / daughter of Late _____

(ii) _____ son / daughter of Late _____

(iii) _____ son / daughter of Late _____

(iv) _____ son / daughter of Late _____

(v) _____ son / daughter of Late _____

(vi) _____ son / daughter of Late _____

being the legal heirs of Late Shri / Smt. _____ have no objection if the entire amount reimbursable pertaining to the treatment of late Shri / Smt._____ is paid to Shri / Smt. _____

(i) Signature
Name :
Address.

(ii) Signature
Name :
Address.

(iii) Signature
Name :
Address.

(iv) Signature
Name :
Address.

(v) Signature
Name :
Address.

(vi) Signature
Name :
Address.

Verified by Notary Public.