**BIRBAL SAHNI INSTITUTE OF PALAEOBOTANY, LUCKNOW**

FORM OF APPLICATION FOR MEDICAL CLAIM *(IN DOOR)*

Form of application for claiming refund of medical expenses incurred in connection with medical attendance and /or treatment of Central Government Servants and their families- For medical attendance/treatment taken from an Authorised Medical Attendant / Hospital. (N.B.- separate form should be used for each patient) - - *(Med.97-A)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | NAME and DESIGNATION of the government servant (in BLOCK letters) | | | | **:** | |  |
| i) Whether Married or Unmarried | | | | **:** | |  |
| ii) If married, the place where wife/ husband is employed | | | | **:** | |  |
| 2. | Office /Division in which employed | | | | **:** | |  |
| 3. | Pay of the Government Servant as defined in the Fundamental Rules, and any 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 Government Servant *(N.B.-In case of children, state age also)* | | | | **:** | |  |
| 7. | Place at which the patient fell ill | | | | **:** | |  |
| **8.** | DETAILS OF AMOUNT CLAIMED | | | | | | |
|  |  |  | | |  |
|  | **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 Govt. Servant and in case 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) | | **:** | | Rs. ............................ |
|  | (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 (List of medicines, cash memos and the “**Essentiality Certificates-B”** should be attached) | | **:** | |  |
|  | (vii) | | Ordinary Nursing | | **:** | | Rs. ......................... |
|  | (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 | | **:** | | Rs. ......................... |
|  | (ix) | | Ambulance charges (State the journey to \_\_\_\_ and from \_\_\_\_\_\_\_undertaken) | | **:** | | Rs. .......................... |
|  | (x) | | Any other charges, e.g. charges for electric light, fan, heater, air conditioning, etc. State also whether the facilities referred to are a part of the facilities normally provide to all patients and no choice was left to the patient | | **:** | | Rs. ........................... |
|  | | | | | | | |
|  | III. CONSULTATION WITH SPECIALIST | | | | | | |
|  | Fees paid to a specialist or a Medical Officer other than the authorised 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 consultation and the fee charged for each consultation | |  | |  |
|  | (c) | | Whether consultation was had at the hospital, at the consulting room of the specialist or Medical Officer, or at the residence of the patient | | **:** | |  |
|  | (d) | | Whether the specialist or Medical Officer was consulted on the advice of the authorised 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 | | **:** | |  |
| **9** | **Net Amount Claimed =** ( Total Amount Claimed - Less Advance Taken ) | | | | **:** | |  |
| DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT  I ................................................. hereby declare that the statements in the application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is not taking medical reimbursement from any other agency.  Dated : | | | | | | | |
|  | PASSED FOR Rs. .................................. | | | (Signature of the Govt. Servant) | | | |

A.C.A.O.

**ESSENTIALITY CERTIFICATES CERTIFICATE (B)**  *(IN DOOR)*

(To be completed in case of indoor patients who are admitted to Hospital for treatment)

Certificate granted to **………….**wife/husband of ………employed in Birbal Sahni Institute of Palaeosciences, Lucknow

**PART ‘A’**

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

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

(b) that I charged and received Rs. …………………………….for administering ……………………. in the venous, intramuscular subcutaneous injections on……………….(date to be given ) at…………… my consulting room the residence of the patient.

(c) That the injections administered were not /were for immunizing or prophylactic purposes.

(d) That the patient has been under treatment at ......................................................., / 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 Hospital .................................................... for supply to private patients and do not included proprietary preparations for which cheaper substances of equal the aphetic value are available nor preparations which are primarily foods, toilets or disinfectants.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sr.** | **Name of Medicine** | **Qty.** | | **Price** |
| 1 |  |  | |  |
| 2 |  |  | |  |
| 3 |  |  | |  |
| 4 |  |  | |  |
| 5 |  |  | |  |
| 6 |  |  | |  |
| 7 |  |  | |  |
| 8 |  | |  |  |  |
| 9 |  | |  |  |  |
|  | **Total** | | |  |  |

(e) That the patient is/was suffering from .................................................................... and is/was under my treatment from ................................................………………………….

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

(g) That the Xray, laboratory test etc. for which an expenditure of Rs……., was incurred was necessary and undertaken on my advice at……*..(name of the hospital or laboratory)*.

(h) that I referred the patient to ...................................... for specialist consultation and that the necessary approval of the Emergency.(name of the Chief Administrative Officer of the State ) as required under the rules was obtained.

(i) That the patient required hospitalization.

**Signature & Designation of the Medical**

**Officer With Stamp.**

**PART-B**

I certify that the patient has been under treatment at .............................................................. 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 and Designation of the

Officer Incharge of the case at the

Medical Hospital

**COUNTERSIGNED**

I certify that the patient has been under treatment at the ......................................................................... and that the facilities provided were the minimum which were essential for the patient’s treatment.

Medical Superintendent

Place ........................ .......................... Hospital

*N.B. – Certificates not applicable should be struck off. Certificate (d) is compulsory and must be filled in by the Medical Officer.*