

# APPLICATION FORM FOR CLAIMING REFUND OF MEDICAL EXPENSES

1. Name and Designation of the Govt. Servant : \_\_\_\_\_
2. Office in which employed and place of duty : \_\_\_\_\_
3. Pay of the Govt. Servant : \_\_\_\_\_
4. (a) Residential Address : \_\_\_\_\_  
(b) Place at which the patient fell ill : \_\_\_\_\_
5. Name of the patient and his/her Relationship to the Government Servant : \_\_\_\_\_
6. Name and Designation of the Medical Officer consulted and the Hospital/Dispensary to which attached : \_\_\_\_\_
7. Details of the amount claimed : \_\_\_\_\_  
(a) For Laboratory X-Ray and Other similar tests undertaken : \_\_\_\_\_  
(b) Cost of medicines purchased From the market : \_\_\_\_\_

Qty.	Name of Medicine	Price	Qty.	Name of Medicine	Price

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

**Signature of the Govt. Servant**  
Dated : \_\_\_\_\_

Encls:

1. Essentiality Certificate
2. Cash memos

B. In column No. 7(a) Please indicate (1) the name of the Hospital or Laboratory where the tests were undertaken and (ii) Whether the tests were undertaken on the advice of the authorized Medical Attendants, if so, a certificate to that effect should be attached.

Reference Government of India, Ministry of health office Memo No. 5-1-8/52 SSC(M) Dated 29..5.53.

Certificate granted to Mr./Mrs. \_\_\_\_\_, wife/Son/Daughter/Father/Mother of Mr./Mrs. \_\_\_\_\_ employed in NETAJI SUBHAS INSTITUTE OF TECHNOLOGY, AZAD HIND FAUZ MARG, SECTOR-3, DWARKA, NEW DELHI – 110045. (To be completed in the case of the patients who are not admitted to the hospital for treatment).

1. 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/intro-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 immunizing or prophylactic purposes.

(d) That the patient has been under treatment at \_\_\_\_\_ 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 CIVIL (name of Hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal the repute value are available nor preparations which are primarily foods, or disinfectants.

<b><u>Name of Medicines</u></b> (In Block Letters)	<b><u>Qty.</u></b>	<b><u>Price</u></b>

- (e) That the patient is/was suffering form \_\_\_\_\_  
\_\_\_\_\_ and is/was under my treatment from  
\_\_\_\_\_.
- (f) That the patient is/was not given pre-natal or now post-natal treatment.
- (g) That the X-ray, Laboratory test etc., for which an expenditure of Rs. \_\_\_\_\_ 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 test the necessary approval officers \_\_\_\_\_ and of the Chief Administrative officer of the State as required under the rules was obtained.
- (i) That the patient did not require/required hospitalization.

Dated : \_\_\_\_\_

**Signature and Designation of the Medical Officer and hospital/dispensary to which attached.**