APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES

INDOOR TICKET NO.: ……… **DATED: ……………………**

1. Certified that Sh./Ms. ……………………………………………….S/o, D/o, Sh. ……………………………………who is employed in the office of Director, Punjab Engineering College, (Deemed to be University), Chandigarh has been under treatment at……………………………………………and that the under mentioned medicines prescribed by me in this connections are absolutely essential for the treatment and recover/prevention of serious detraction in the condition of the patient. The medicines were not on stock in the stores of the above said Hospital/Dispensary for supply to entitled patients and do not include proprietary preparations for which cheaper substitute of equal therapeutic value are available and are neither preparations which are primarily food, toilets and disinfectants.

2. **Certified that treatment as indoor patient was necessary.**
3. **Certified that the medicines were born/not borne on the list of medicines store Department.**
4. **Certified that the medicines are not in the nature of tonic etc.**
5. **Certified that the medicines charges have no cheaper effective substitute.**
6. **Certified that the medicines prescribed are not in the list of non-reimbursable medicines/articles last revised vide Punjab Govt. Letter No. 170-I-S/15351-HBT-66/7796 dated 25.2.1960.**
7. **Certified that the prices claimed are reasonable.**
8. **He/She was suffering from……………………………………………………………………………**
9. **Period treatment from……………………………………………to……………………………………..**

Sr. No.	Medicines	Chemist	No. & date of cash memo	Amount (Rs.)

Signature of Authorized Medical Officer with Designation

1. **Certified that my mother/father is wholly dependant upon me and residing with me. He/She has no source of income of his/her own, what so ever.**
2. **Certified that my wife/son/daughter/sister is wholly dependant upon me and residing with me. He/She is not in Govt. Service.**
3. **Certified that the treatment pertains to my…………………………………………………………….**
4. **Certified that the medicines were purchased and consumed during the period of treatment.**
5. **Basic pay Rs. …………………………..Special Pay Rs………………………………………………………**

Dated:

Signature of Govt. Employee
Designation……………………….
Department……………………..
Punjab Engineering College
(Deemed to be University) Chandigarh
Mobile No. ______________
Extension No. ____________

DATE OF RETIREMENT __________________

RESIDENTIAL ADDRESS ____________________________

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FORM OF APPLICATION FOR MEDICAL CLAIMS

N.B. – Separate form should be used for each patient

1. Name and designation of the Govt. Servant (In block letter) :

2. Office in which employed :

3. Pay of the Govt. Servant as defined in the Fundamental Rules 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 Govt. Servant :

7. Place at which the patient fell ill :

8. Details of the amount claimed :

   I. Medical Attendance :
   II. Fees for consultation indicating :

   a. the name & the designation of the Medical Officer consulted and the hospital or Dispensary of which attached :
   b. the numbers and dates of consultation & the fee paid for each consultation :
   c. the number and dates of injection & the fee paid for each injection :
   d. Whether consultation and or injections were at the hospital & the consulting room of the medical officer or at residence of the patient :

   II. Charge for pathological, bacteriological, Bacteriological, radiological or other Similar test undertaken during diagnosis Indication.

   a. the name of the hospital or laboratory where the tests were undertake on the advice of the authorized medical attendant if so, a certificate to the effect should be attached

   III. Cost of medicines purchased from the market :

(List of the each memos and the essentiality certificate should be attached)

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9. Total amount claimed :
10. Less advance taken on _______________ :
11. Net amount claimed :
12. List of enclosures :

Declaration to be signed by the Government Servant.

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

It is certified that I have purchased the same medicine as prescribed by the doctor for the period ___________ to ________ (for ________months) which pertain to Chronic Disease Only(Photocopy attached). It is further certified that I/patient will consume the above said/same medicine with in the treatment period.

Date :

Signature of the Govt.
Servant and office to which attached.

UNDERTAKING

i. I ____ hereby undertake that I am not claiming reimbursement from any other organization/ Insurance Company against my medical claim of Rs. ____________/- for the period from __________________________ to _________________________.

ii. That my wife Mrs. ____________________________________ is not Income Tax payee and she is fully dependent upon me and residing with me.

iii. That I/my wife has not taken any medical insurance policy

(______________________)
Signature

Mobile No. _____________________

Bank A/C No. ___________________

IFSC Code _____________________

PPO No. _______________________

Date of Retirement _______________

………

DECLARATION

"I ____ working / worked as ______________ S/O, D/O Sh. ___________________________ aged ______________ R/O ____ __________________________ Chandigarh/ Distt/ State verify that the above contents are correct to the best of my knowledge and belief and nothing has been concealed therein. I am aware that in case the information furnished above is found to be incorrect. I shall be liable for prosecution under Section 177 & 191 of the Indian Penal Code, which stipulates imprisonment and fine."

Dated:

(______________________)

Attach Photograph

Signature

ANNEXURE – 'B'

COMPLICATED CHRONIC DISEASE CERTIFICATE

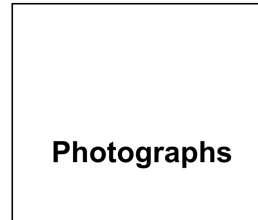
Name of the State Govt: No. of Certificate_________

Medical Hospital/Institute

Issuing Certificate Date of Issue: ___________

Validity of : From_____________________

Certificate: To________________________



Certified that Mr./Mrs. ____

Son/daughter/Husband/Wife of S/Sh.____

Age ________________working in/retired from the office of the ____________________ as_____________________ and resident of House No. ___________________________

Village/City/Town ___________________ Distt. _______________________has been examined in this Govt. Medical College/Institute by Dr.(s) _________________________ today on _______________. He/She is suffering from ___________________________ and this disease has been declared as Complicated Chronic Disease by Punjab Govt., vide Annexure 'A' of their letter No. 12/69/98-5HBV/21329-21333, dated the Ist September, 2000. P.P.O. No._________________________________(in case of retiree).

Signature of the patient examined ____________________________.

The patient shall present himself/herself on ____________________ for fresh check – up.

Name & Signature of the
Head of the Department
In which the patient is
Examined (with Seal).

Name (s) & Signature (s) of
Doctor (s) with Seal.

1. __________________

2. __________________

Name & Signature of Principal / Medical Superintendent of the Institute (with seal)