**EXTRACT OF MEDICAL CLAIM**

01. Name of the Govt.Servant together with :

The designation and section in which he/ :

She is working and pay drawn :

02. Residential address and place at which the :

Patient fell ill. :

03. Name of the patient and his/her relationship :

With the Govt.Servant ( in the case of children, :

State age.) :

04. Name of the disease and period of medical :

Medical treatment/ attendance and treatment :

As given in the essentiality certificate. :

05. Name of the Authorized Medical Attendant and :

Hospital to which attached. :

06. Fees paid to authorized medical attendant :

(No. and date of authorized medical attendant’s

Receipt) :

07. a. No. and date of consultation :

b. No.of injections administered with dates :

Intra muscular injections on :

08. Details of medicines prescribed and included in Essentiality Certificate

(Details of cash Memos)

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| --- | --- | --- | --- | --- |
| S.No. | Name of company/Pharmacy | No.& dt.of Bill | Name of medicine | Amount Rs. |
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09. Radiology and other costs included in essentiality

Certificate for payment.

a.

b.

c.

10. Other charges and ambulance charges etc to be

Filled in the case of an impatient of hospital :

11. Details of Hospital Stoppage for payment of Rs.:

12. Allocation of charges:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medical Advance nursing and accommodation | Diet | Consultation | Injection | Lab  Ch. | Xray/  Sacn/  ECG/  Radio  Logy/  others | Surgery/  Opera-  Tion/  Dress-  ing ch. | Medicines | Others | Total |
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13. Details of medicines ( to be filled in as directed :

In col.No.8)

14. Other charges :

**TOTAL** :

**DECLARATION TO BE SIGNED (IN FULL) BY THE GOVT.SERVANT.**

I do hereby declare that the particulars furnished above are correct to the best of my knowledge and belief.

Signature of the Government Servant

Name and Designation.

Date:

FOR OFFICE USE ONLY

Claim scrutinized and passed for payment Rs.

(Rupees

**ESSENTIALITY CERTIFICATE**

Certificate granted to Mr./Mrs./Miss. Son/ daughter/ wife/ father/ mother of Mr./Mrs./Miss employed in the Income Tax Office, .

**CERTIFICATE –A**

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

I, Dr. hereby certify that :-

a. I charged and received Rs. for Consultations on at my consulting room / at the residence of the patient.

b. I charged and received Rs. For administering intravenous / intramuscular / subcutaneous injections on at my consulting room / at the residence of the patient.

c. The injections administered were/ were not for immunizing or prophylactic purposes/

d. That the patient has been under treatment at my consulting room and that the undermentioned medicines prescribed by me in this connection were essential for the recovery of the patient.

The medicines are not stocked in the Government

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 foods, toilets or disinfectants.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| S.no. | Name of medicine | Amount | S.No | Name of medicine | Amount |
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e. That the patient is/was suffering from and

is / was under my treatment from to .

f.That the patient was/ was not given pre-natal treatment.

g. That the X-Ray, Laboratory test, etc for which an expenditure of 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 necessary approval of the (Name of the chief administrative Medical Officer of the State) as required under the rules was obtained.

i. That the patient did not require / required hospitalization.

j. That the mixture / ointment/powder entered at serial No. under certificate (d) could not be dispensed at the hospital and the patient was advised to buy it from the market.

k. That the period of treatment / no.of injections in excess of the prescribed one was / were essential for the complete recovery of the patient.

/seal/

Date:

(Signature, Designation & Regd. No. of the Medical officer &

The 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.

**CERTIFICATE**

Certified that I, Employed in the Income Tax Office, , am not availing of any Medical Facilities or financial / Medical allowances in lieu thereof either for myself or the members of my family / from any other sources other than the CS(MA) Rules, 1944.

(Signature of the Government Servant)

Place :

Date :

**CERTIFICATE ‘B’**

**(To be completed in the case of patients who are admitted to hospital for treatment)**

Certificate granted to Mr./Mrs./Miss. C.V.GOPINATHAN, Son/ daughter/ wife/ father/ mother of Mr./Mrs./Miss. employed in the Income Tax Office, .

**PART –A**

I, Dr. hereby certify 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 (name of the hospital) and 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 (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 foods, toilets or disinfectants;

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| S.no. | Name of medicine/disposibles | Amount | S.No | Name of medicine | Amount |
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c. The injections administered were/ were not for immunizing or prophylactic purposes/

d. That the patient was suffering from and

is / was under my treatment from to

e. 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)

f. That I referred the patient to 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.

*Name of the medical officer incharge*

*Of the case in the hospital*

**I CERTIFY THAT;**

The patient has been under treatment at the (name of the hospital)and that the service of 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.

/seal/

*Name of the medical officer incharge*

*Of the case in 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.

Place:

*Medical Superintendent*

*(Name of the hospital)*

\* the minimum facilities certificate may be signed either by the Medical Superintendent of the Hospital concerned or another Gazetted Medical Officer who has been authorized in this behalf by the Medical Superintendent [G.I. MH. OM No.F.2-35/52-LSG(Hi) dated 19-09-1958]

**Med.97**

**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.**

1. Name and designation of Government servant :

(in block letters) :

i) Whether married or unmarried :

ii) if married, the place where wife/husband :

is employed. :

2. Office in which employed :

3. Pay of the Government servant as defined in :

The Fundamental Rules, and any other emolu- :

ments 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 :

*(in the case of children, state age also)*  :

7 Place at which the patient fell ill :

8. Details of the amount claimed. :

**Medical Attendance** –

i) Fees for consultation indicating -

a. the name and designation of the medical :

officer consulted and the hospital or :

dispensary to which attached :

b. The number and dates of consultation and :

the fees paid for each consultation :

c. The number and dates of injection and the :

the fees paid for each injection :

d. Whether consultation and / or injections were

had at the hospital, at the consulting room :

of the medical officer or at the residence of :

the patient. :

ii) Charges for pathological, bacteriological, radio-

logical, or other similar tests undertaken during

diagnosis indicating –

a) The name of the hospital or laboratory :

where undertaken; and :

b) whether the tests were undertake on the :

advice of the authorized medical attendant. :

if so, a certificate to that effect should be :

attached. :

iii) Cost of medicines purchased from the market. :

(Cash memos and the essentiality certificates :

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 Govt.Servant, a certificate should :

Be attached to the effect that the accommod- :

ation 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 :

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 essen- :

tiality certificates should be attached) :

vii) Ordinary Nursing :

viii) Special Nursing, ie.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 :

fro undertaken) :

x) Any other charges, eg. Charges for electric :

light, fan, heater, air-conditioning, etc. State :

also whether the facilities referred to are a part :

of the facilities normally provided to all :

patients and no choice was left to the patient :

Note-1 If the treatment was received by the Government

Servant at his residence under Rule 8 of the Secretary

Of State’s service (MA) Rules, 1938, or Rule 7 of the C.S.

(MA) Rule, 1944, give particulars of such treatment

And attach a certificate from the lauthorized medical

Attendant as required by these rules.

Note-2 Deleted Vide OM Dated 01/17-10-2007

**III. Consultation with specialist.**

Fees paid to 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) Whether consultation was had at the hospital :

or 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 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

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 the application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is sholly dependent upon me.**

DATE:

Signature of the Government Servant

And office to which attached.