

Claim for Reimbursement of Medical Charges For Out-Patient Treatment

Check List to be signed and furnished by the (APGENCO) Employee

Indicate 'Yes' or 'No'
in the Brackets against
each item.

1. All the Columns of the application form have been filled in properly ()
2. The bill has been submitted alongwith Essentiality Certificate 'A' for the treatment as Out-Patient by Furnishing all the particulars and signed by the Medical Attendant who treated the Patient. ()
3. The bill has been submitted alongwith the Essentiality Certificate 'B' for the treatment as In-Patient by furnishing all the particulars and signed by the Medical Attendant who treated the patient and countersigned by the Head of the Hospital. ()
4. The name of the disease has been indicated in the essentiality certificate in block letters. ()
5. The Period of Treatment has been specifically indicated in the essentiality certificate. ()
6. The case Doctor has signed on the essentiality certificate and countersigned by the Head of the Hospital. ()
7. All the Columns of Essentiality Certificate 'A/B' have been filled in properly. ()
8. All the Cash receipts are within the period of treatment. ()
9. The cash receipts have been countersigned by the Doctor who treated the patient. ()
10. The name of the patient and name of the Doctor has been indicated in all the cash receipts. ()
11. All the cash receipts enclosed to the Medical Reimbursement claim are dated. ()
12. The total amount of cash receipts tallied with the amount claimed. ()
13. The duplicate bill with the copies of the original bills has been submitted. ()

(SIGNATURE OF THE EMPLOYEE)

Certificate to be furnished by the Forwarding Officer

1. The bill is submitted within three months from the date of completion of treatment.
2. The application is as prescribed by the (APGENCO).
3. The application form has been signed by the employee/countersigned by the controlling Officer with dates.
4. The name of the disease is indicated in Block Letters in the essentiality certificate certifying that it is a Chronic Disease.
5. The Medical Bill of the employee has been thoroughly scrutinised in the light of the instructions and guide-lines issued in para 14 of Boards Memo No DP/DM (A) F3/2487/85-16, Dt. 25-4-89 and the statement is furnished.
6. The total amount of reimbursement so far sanctioned to the employee is Rs.....
7. Prior permission from the competent authority for taking treatment outside the state has been obtained in Memo. No.....Date.....
8. The claim is within the powers of CMD/APGENCO vide/G.O.O No. 572 Dt. 24/12/2002

ATTESTATION OF THE
FORWARDING OFFICER

FORM OF APPLICATION FOR MEDICAL CLAIMS

1. Name of the Employee.
2. Date of Birth.
3. Designation and Basic pay.
4. Section and office in which employed.
5. Actual Residential Address.

6. Office and place where wife/
husband is employed if both
are employed.
7. Name of the patient and relationship
(in case of children, state age also)
8. Name of the Medical Attendant
and address and Name of the
Hospital.
9. Name of the Disease in block
letters.
10. Period of treatment as in patient/
out patient as indicated in the
Certificate.
11. Details of medical charges incurred
Medical Attendance:-
 - a) The No. and dates of consultations
and fees paid for each consultation.
 - b) The No. and dates of injections
and fees paid for each Injection.
 - c) Details of Laboratory tests
X-Ray charges etc.
 - d) Cost of Medicines (Details of the
consolidated medicines shall be
furnished in the essentiality
certificate)
12. Hospital Treatment :-
 - a) Accommodation Charges.
 - b) Diet Charges.
 - c) Lab charges (details shall be furnished).
 - d) Cost of Medicines supplied in the hospital.
 - e) Surgeon's fee.
 - f) Asst Surgeon's fee

Contd.

- g) Anaesthetist fee
 - h) Theatre charges,
 - i) Nursing charges,
 - j) Blood charges.
- 13. Total amount claimed
 - 14. Less advance taken on
 - 15. Net amount claimed
 - 16. No. of enclosures.

Declaration to be signed by the Employee

I hereby declare that the statements furnished above are true to the best of my knowledge and belief and the person for whom the above medical expenses were incurred is wholly dependent on me.

Place

Date

SIGNATURE OF THE EMPLOYEE

countersigned and forwarded to CMD (APGENCO)/GM incharge of the Subject for necessary action.

(SIGNATURE OF THE CONTROLLING OFFICER)
(with date and Designation)

Note :- The claim shall be supported by Essentiality certificate and cash receipts of the expenses shall be countersigned by the Doctor/Medical Officer.

All the cash receipts shall be within the period of treatment as indicated in the essentiality certificate. They must necessarily contain the name of the patient, name of doctor and date of issue.

The claims of the employees other than those opted for treatment at the (APGENCO) Dispensaries shall be only for chronic diseases like T.B. or other major operations and the same shall be indicated by the Doctor in the essentiality certificate.

All the medical Bills shall be submitted to their controlling Officers within three months from the last date of the treatment period who in turn after scrutiny, forward to the sanctioning authority as per the powers delegated in G.O.O No. 572 Dt. 24/

ESSENTIALITY CERTIFICATE - A

(To be completed in the case of patient who are admitted in the Hospital for treatment)

Certificate is granted to Mr./Mrs./Miss _____

Wife/Son/Daughter of Mr. _____

employed in the office of the _____

I, Dr. _____ hereby Certify

- (a) that I charged and received Rs. _____ for _____ consultations on _____ at my consulting room / at the residence of the patient.
- (b) that I charged and received Rs. _____ for administering injections on _____ at my consulting room / at the residence of the patient.
- (c) that the injections administered were not 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 were not stocked in the _____ (name of the hospital) for supply to private patients and do not include proprietary preparation for which cheaper substances of equal therapeutic value are available nor preparations which are primarily food, toilets or disinfectants.

Sl. No.	Name of the Medicine	Price	Sl. No.	Name of the Medicine	Price
			Total Rs.		

- (e) that the patient is/was suffering from _____ which is chronic/not chronic/major operation/minor operation) and is/was under treatment from _____ to _____ as in patient and from _____ to _____ as out patient.
- (f) that the patient is/was not given pre-natal or post-natal treatment.
- (g) that the X-ray laboratory tests etc. for which an expenditure of Rs. _____ was incurred was necessary and were undertaken on my advice at _____
- (h) that I referred the patient to Dr. _____ for specialists consultation and that the necessary approval of the _____ as required under the Rules was obtained.
- (i) that the patient did not require/required hospitalisation.

SIGNATURE AND DESIGNATION OF THE
MEDICAL OFFICER