

**FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL TREATMENT
INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND/OR TREATMENT
OF CENTRAL GOVT. SERVANTS AND THEIR FAMILIES.**

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|--------------|---|---|-----------|---------------------------------|-----------|---------------------|-----------|---------------------------------|-----------|-------------------------------|
| 1. | Name and designation of the Government Servant (in block letters) | | | | | | | | | |
| 2. | Office in which employed | | | | | | | | | |
| 3. | Pay & Allowance to be shown separately – Pay, DA, CCA, HRA = Total | | | | | | | | | |
| 4. | Place of Duty | | | | | | | | | |
| 5. | Actual Residential Address | | | | | | | | | |
| 6. | Name of patient and his/her relationship to the Govt. Servant | | | | | | | | | |
| 7. | Place at which the patient fell ill | | | | | | | | | |
| 8. | Details of Amount claimed | | | | | | | | | |
| (i) | Medical Attendance : | | | | | | | | | |
| | (a) Name, Address & Designation of the Medical Officer consulted and the hospital or dispensary in which attached. | | | | | | | | | |
| | (b) No. & date of consultation and fees paid for each consultation. | | | | | | | | | |
| | (c) No. & date of injections and fees paid for each injection. | | | | | | | | | |
| | (d) Whether consultation or injections were had at the hospital/consulting room or at the residence of the patient. | | | | | | | | | |
| (ii) | Indoor Hospital Treatment | | | | | | | | | |
| (iii) | Medicines purchased from the market. (List of medicines, cash memo & essentiality certificate should be attached) | | | | | | | | | |
| 9. | Total Amount Claimed | | | | | | | | | |
| 10 | List of Enclosures | <table border="1"> <tr> <td>1.</td> <td>Doctor's prescription(s)</td> </tr> <tr> <td>2.</td> <td>Cash Memo(s)</td> </tr> <tr> <td>3.</td> <td>Essentiality Certificate</td> </tr> <tr> <td>4.</td> <td>Other (Please Specify)</td> </tr> </table> | 1. | Doctor's prescription(s) | 2. | Cash Memo(s) | 3. | Essentiality Certificate | 4. | Other (Please Specify) |
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| 2. | Cash Memo(s) | | | | | | | | | |
| 3. | Essentiality Certificate | | | | | | | | | |
| 4. | Other (Please Specify) | | | | | | | | | |

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 wholly dependent upon me.

Place :

Signature of the Government Servant.

Certificate granted to _____ son/daughter/wife/husband
of Mr./Mrs. _____ employed in the _____
department at _____.

C E R T I F I C A T E

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

I, Dr. _____ hereby certify that

- (a) I charged and received Rs. _____ for consultation/s on _____.
- (b) I charged and received Rs. _____ for administering _____
intramuscular injections or subcutaneous on _____ at my consulting room / the
residence of the patient. (dates to be given)
- (c) That the injections administered were/not for immunizing or prophylactic purposes,
- (d) That the patient has been under treatment at _____ hospital/my
consulting room and the undermentioned medicines prescribed by me in this connection were
essential for the recovery/prevention of serious deterioration in the condition of the patient and
the medicines are not stocked in the _____ (name of hospital) for supply to
private patients and do not include proprietary preparations for which cheaper substances of
equal therapeutic value are available; no preparations which are primarily foods, toilets or
disinfectants;

