MAHATMA GANDHI UNIVERSITY

FORM OF APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES OF UNIVERSITY EMPLOYEES AND THEIR FAMILIES

1. Name and Designation of the Employee (In Block Letters) :

   Mobile No. :

2. Pay and scale of pay :

3. Office / Dept. in which employed :

4. Telephone Extn. No. of the Section/Dept. :

5. Residential address and Phone No. :

6. Name and relationship of the patient to the employee :

7. Place at which the patient fell ill :

8. If the patient is a spouse of the employee state whether she/he is employed, with details :

HOSPITAL TREATMENT

9. System of treatment :

10. Whether hospitalized or not :

11. If hospitalized whether in Govt. Hospital or Private Hospital (Specify the name of Hospital) :

12. If hospitalized outside the State :

    a) Whether the Patient was on duty :

    b) Name of Institution :

13. If on special treatment outside the state :

    (a) Name of Institution :

    (b) Whether certificate from the local expert (Not below the rank of a Civil Surgeon) is attached :

    (c) Whether prior sanction of the University has been obtained

14. Last date of treatment :

CHARGES

15. Details of amount claimed (list of Medicines, Cash Memos and Essentiality certificate should be attached) :

1) Treatment in Govt. Hospital Medicines :

2) Treatment in Private Institutions (bills to be certified indicating emergency of the case) : :

(a) Charges for Medicines :

(b) Charges for Treatment :

(c) Charges for Accommodation :

(d) Charges for Lab. services etc. :

(e) Charges for Diet :

16. Total amount claimed in figures and words :

17. List of enclosures :

(a) Essentiality Certificate :

(b) List of Cash Bills :

(c) Certificate of Medical Officers :

(d) Declaration/Certificate :

(e) Prescription in the case of Ayurvedic/ Homoeopathic treatment :

DECLARATION TO BE SIGNED BY THE EMPLOYEE

I hereby declare that the statements given above are true to the best of my knowledge and belief and that the persons for whom the medical expenditure has been incurred is wholly dependent on me.

Date:

Place: Signature of the Employee

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ESSENTIALITY CERTIFICATE

I, Dr. ....certify that

Sri./Smt .... employed in the

.... University Office / Department has been under treatment at this Hospital or at his / her residence for the period from ....

to .... 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. They do not include proprietory preparations for which cheaper substance of equal therapeutic value are available, nor preparations which are primary foods, tonics, toilet preparations or disinfectants.

It is certified that the case did not require hospitalisation but is one of prolonged nature requiring medical attendance at the outpatient departments spreading over a period of more than 10 days.

The patient aged.. was / has been suffering from .... (Name of disease)

Trade / Brand name of medicine	Chemical / Pharmacological name of medicine	Description Bill No. and date	Price	
			Rs.	Ps.
(I)	(2)	(3)	(4)	

Total Rupees... TOTAL:

....

Place :

Date :

(OFFICE SEAL)

Remarks of the Medical Director of the University

Signature

Name & Designation of the authorised Medical Attendant

Registration No:

System of Treatment:

FOR OFFICE USE ONLY

Passed for payment of Rs ....

.... only.

Assistant

Section Officer

Assistant Registrar.

DECLARATION

I ....
employed in the University Office / Department
OR
(in the case of treatment of the dependent)

(Name)..

(Relationship)..of mine

have / has been under treatment at the..

....

Hospital / Dispensary / at my residence during the period of treatment

from...to...

and I / he / she have / has received the benefit of one system of treatment and not taken advantage of more than one system simultaneously. He / She is not employed.

Signature :

Name and
Designation :

Section /
Department :

Station :

Date :

CERTIFICATE

Certified that Sri. / Smt...

....is solely dependent on me.

Signature :

Name and
Designation :

Section /
Department :

Station :

Date :