APPLICATION FORM FOR REIMBURSEMENT OF OPD MEDICAL EXPENDITURE

1. **Name of the Government Servant** : ……

2. **Designation** : ……

3. **Division/ Section/ Unit** : ……

4. **Pay Level/ Grade Pay** : ……

5. i. **Whether married or unmarried.** : ……
   ii. **If married the place where wife/ husband is employed** ……

6. **Name of patient & his/her relationship with the Govt. servant** : ……

7. **DETAILS OF THE AMOUNT CLAIMED:**

I. Medical Attendance:

i. **Name and designation of the Medical Officer/ Hospital consulted.** : ……

ii. **The dates of Consultation and the amount of Consultation Fees paid.** : ……

iii. **The number and date of injection and fee paid for each injection.** : ……

iv. **Whether consultancy and/or injections were had at the hospital or at consulting room of the doctor** : ……

II. Charges for pathological bacteriological, radiological or other similar tests undertaken during diagnosis indicating: : ……

i. **Name of the hospital or laboratory where tests were undertaken** : ……

ii. **Whether the tests were undertaken on the advice of AMA. If so, provide a certificate to that effect.** : ……

III. Cost of the medicines purchased from Market (Cash Memo & the essentially certificates should be attached) : …….

IV. Total Amount claimed : …….

8. List of enclosures : …….

DECLARATION

I hereby declare that:

1. **The statements made in the Application are true to the best of my knowledge and belief.**
2. **The reimbursement is being claimed for the amount which has been actually incurred by me.**
3. **The person for whom medical expenses were incurred is wholly dependent upon me.**
4. **All the bills and vouchers have been countersigned by the Medical Authority.**

Place:

Dated: **Signature of the Employee**

Forwarded by concerned Head/ in-charge

(Name, Designation & Dated Signature)

ESSENTIAL CERTIFICATE 'A' (For OPD Patients only)

Certificate granted to Mr./ Mrs./ Miss/ Dr./ …….…….…….

Wife/ son/ Daughter of Mr./ Mrs./ Dr…….…….……

Employed in the ……

CERTIFICATE

I, Dr…….. hereby certify that:

a. **That I have charged and received Rs. …… for consultations on ……..….. (dates to be given) at my consulting room/ ……...……Hospital/ at the residence of the patient.**

b. **That I have charged and received Rs……...…….... for administering Intravenous/ Inter muscular / Subcutaneous injection on……..…… at my consulting room/ …….Hospital/ at the residence of the patient. That the injections administered were/ were not for immunizing or prophylactic purpose.**

c. **That the patient has been under treatment at my consulting room/ …….. Hospital/ at the residence of the patient and that 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 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:**

Sl. No.	Name of the Medicines/ Cash Memo No. with Date	Total Amount (in Rs.)
	TOTAL AMOUNT FOR MEDICINES	

d. That the patient is /was suffering from ……..……..…… (in block letters) and is / was under my treatment from ……. to ……

e. That the patient is /was not given prenatal/or post natal treatment.

f. That the pathological, bacteriological, radiological or other similar tests for which an expenditure for Rs. ……..…..……. was incurred were necessary and were undertaken on my advice at …….…… (Name of the hospital / Laboratory).

g. That I referred the patient to Dr. ……. for specialist consultation and that the necessary approval of the ……..……as required under the rules was obtained.

Medical Officer States:

1. **That the patient did not required hospitalization.**
2. **That the treatment is over/continued**

(Strike out which is Not Applicable)

Place:

Dated:

Signature of the Doctor/ M.O.
(with Seal)